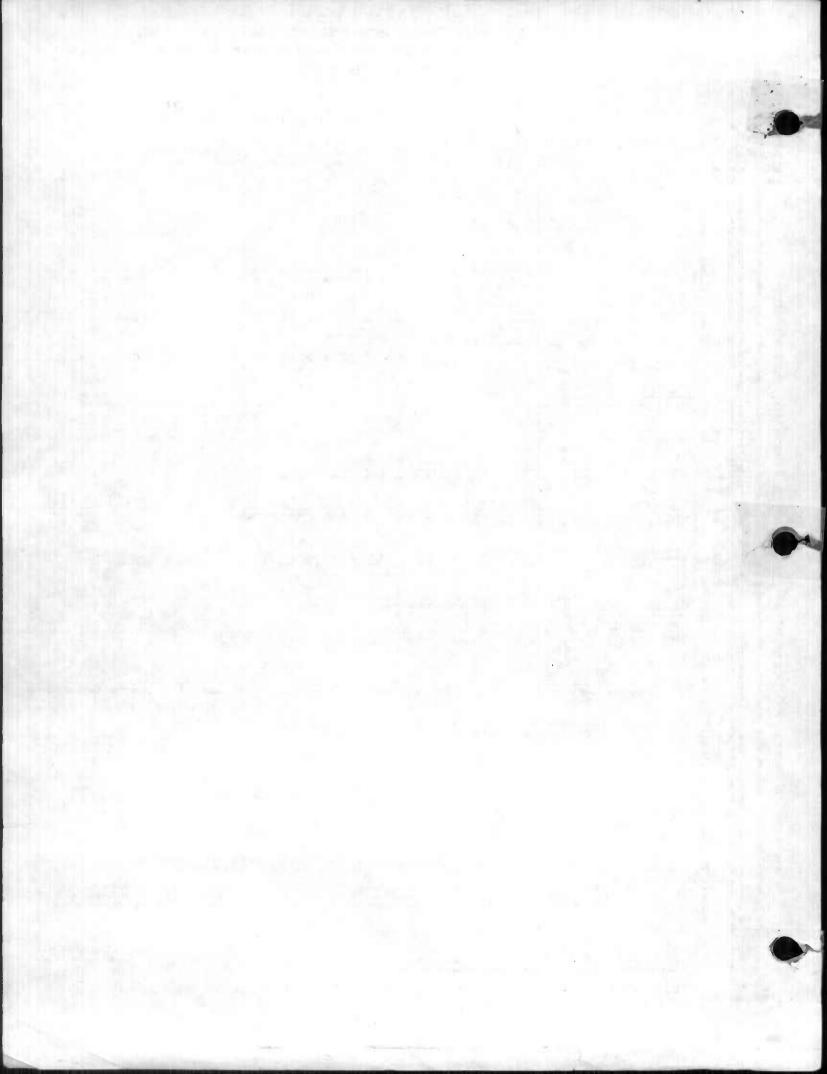
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State of Maryland / Department of Health and Mental Hygiene 3 7 0 0

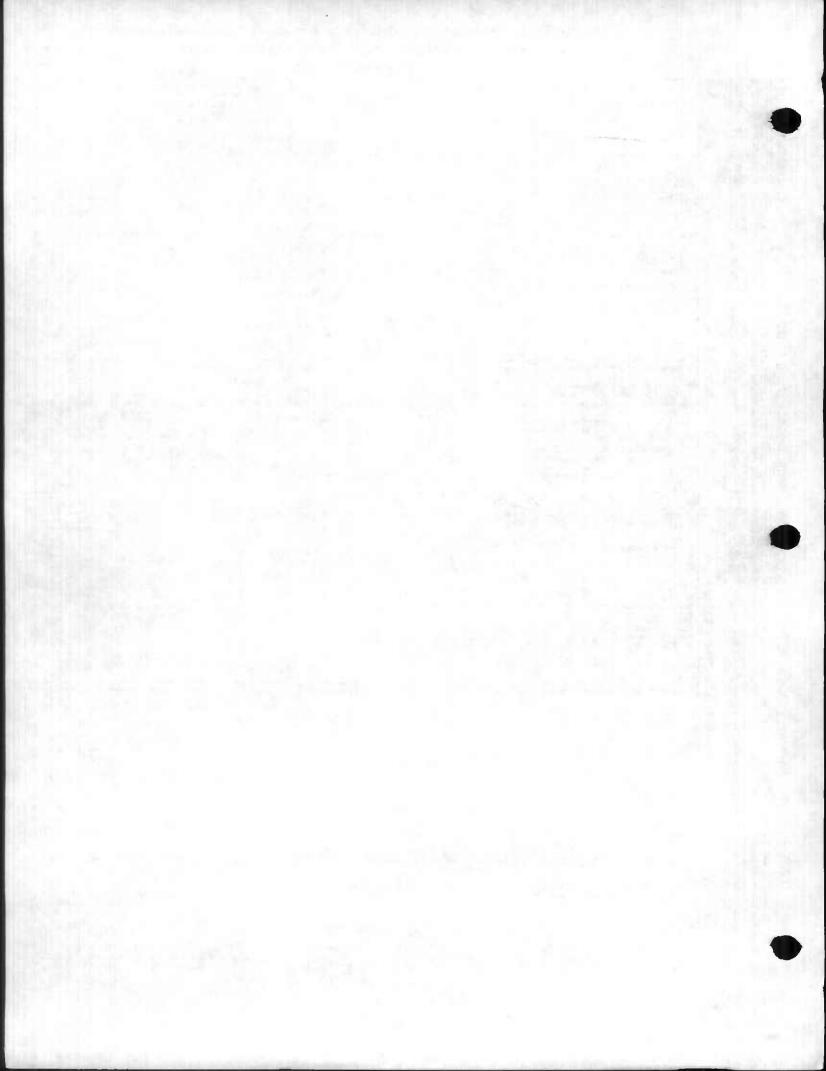
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State of Maryland / Department of Health and Mental Hygiene 00 37002

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	1. Decedent'e Neme (First, I	Aiddle, Las	it)							2. Dete of Dea Month	th Day	Year	3. Time of Dea	łh
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Examiner	4e Facility Neme (If not insti			nber)		100	4		wn, or Lo	cation of Death		y of Deeth		
Funeral Director	5. Social Security Number 229–46–1696	6. Se		7. Age (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Birth (Month, Dey	7, Year) 3–1934	Cou	place (State or For intry) pinia	eign
	Usual Residence of Deceder									05 0.	1 1/51	VILL	barra de la companya	
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page 2										1 🗆 Y	es 20 No	1	TYes 20 No	
s certificate had director, page	25. Wes case referred to me examiner?	dical						26. Plac	e of Deet	h (Check only o	ne)			
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within 24 hours at To the Funeral Di completaly filled in Medical Cer			vsician: To the	best of my know	wledge, deet	h occurred	at the tir			and due to the cred et the time, c				
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7	30. Neme end address of pe			e of deeth (Item			. В	ALTIA	102	E MD	2120	2		
State Registrar	31. Dete filed (Month, Day, 1) NOV 2 2		32 R	egistrar's Signat	Lure	Som	61	,						

DHMH 16 Rev 6/95



State of Maryland /	Department	of Health and	Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 18, 2000 **Physician** Novel Marie Glass /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 900 West Northern Parkway Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 224-32-7554 Yrs. 87 **Director** 06/08/1913 North Carolina Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 28a-f show Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code hygens, other than "natural", or hems 23a or ent, the Medical Examiner must be 900 West Northern Parkway 21210 United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Nevar Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE g 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental it is marked or Gabriel Alfonso Kemp Carrie Harris omit Pages 1 and 2 aho.
Department of Health and Important it flam 27 any injury or any injury or and injury or and injury or any injury or and injury or any injury or and injury or an 19a. informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Cavenaugh Daughter 900 West Northern Parkway, Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 11 - 21Mt. Lawn Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) North Wilkesboro, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Avenue, Baltimore, MD 21228 complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, **Physician** Immediate Cause (Final disease or condition rasulting in deeth) /Medical neumonen Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury and attending physician for use as the burie Box 68760. that initiated events resulting in deeth) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown HYPO TITYEUD Be Completed by 24b. Were autopsy tindings 24a. Was an eutopsy performed? 1 Yes 2 No

After this certificate has been signed by the rifuneral director, page 2 should be detached Division of Vital Records, or Attending Physician: after death. Director: / To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28b. Time of Injury et Work? 28d. Describe how Injury occurred 1 Matural 5 Pending Injury 1 Yes 2 No investigetion 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signatura and fittle of certifier

29a. Certifier

29c. Licanse number DZ6394 29d. Date signed (Month, Day, Year)

3. Time of Death

8:15 AM

10d. Inside City Limits

Approximata Interval Between Onset and Death

evailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEGEIN 720

ULIO SPRING LA BALTO MI)

State Registrar

Certification: To

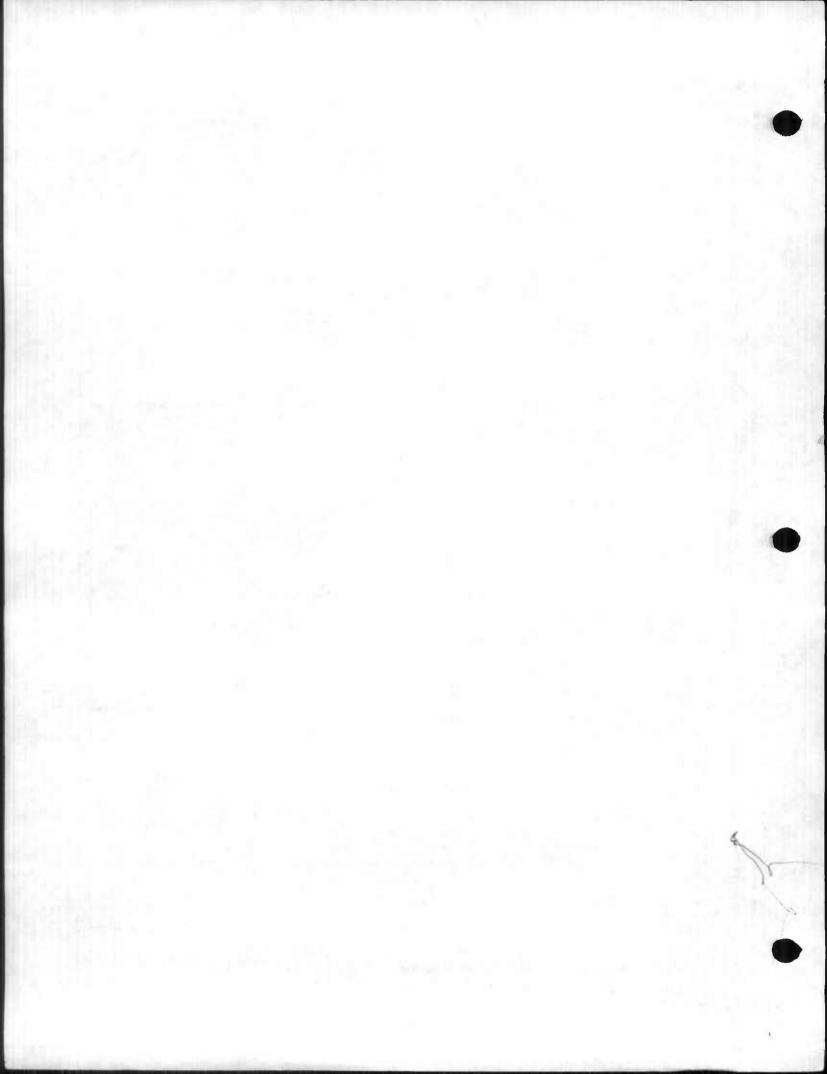
Medical

31. Data filed (Month, Day, Year) NOV 2 2 2000

Dweld 7 W

32. Registrar's Signeture Beneva

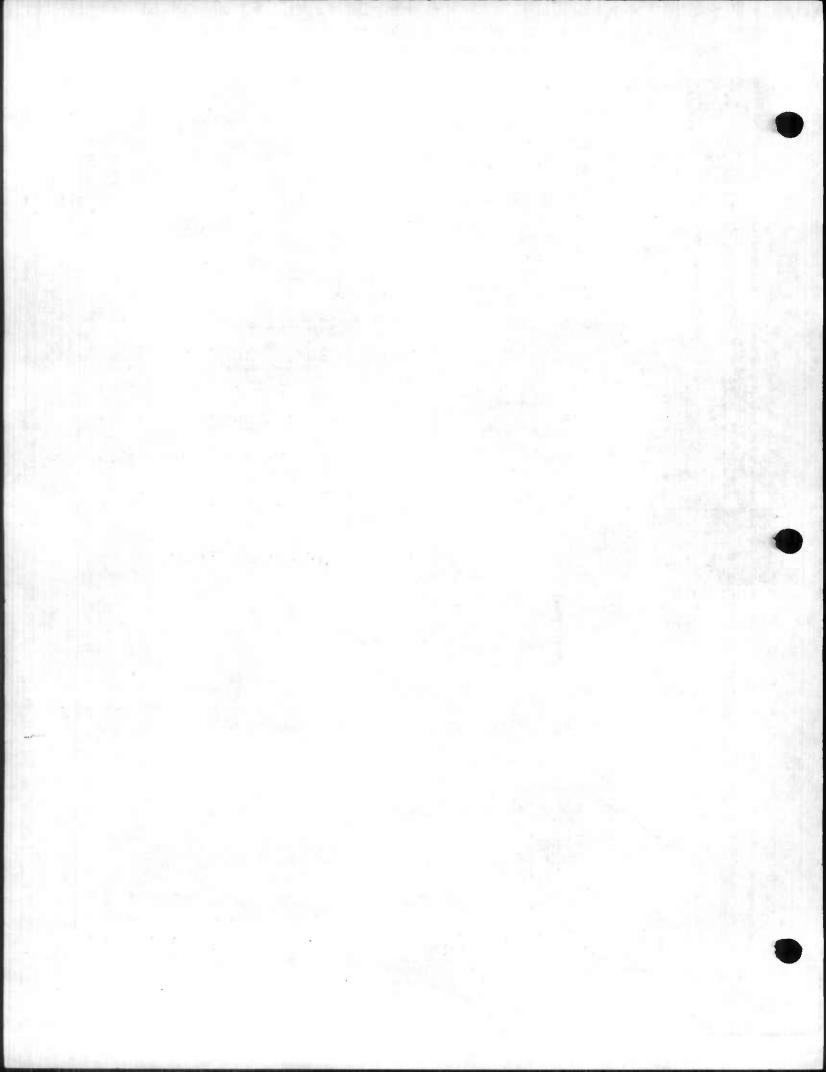
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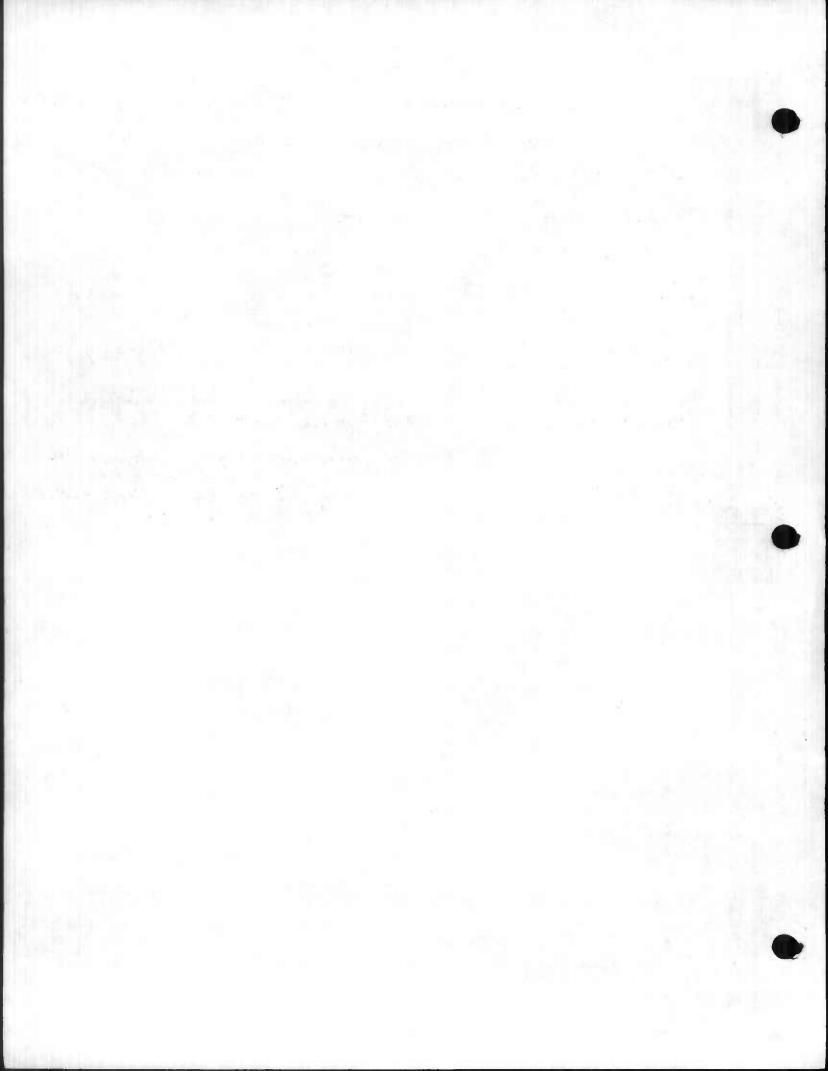
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

JOHN D. GREGORY JOHN D. GREGORY ACOUNT OF DAME COUNTY OF DAME CO	ral tor Us 10 Percent	le Facility Name (If not institution, git 2 400 MONKTON F Social Security Number 6 1029-18-37-3 Usuel Residence of Decedent 10a. State 10b. County MD BALTIN 10a. Street and Numbar 2 400 MONKTON F 11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced (Specily only highest git 17. Father's Name (First, Middle, Last JOHN GREGORY 19a. Informent's Neme/Reletionship POLLY GREGORY 20a. Method of Disposition 1 Burial 2 Cremetion 3 5 4 Donetion 5 Other (Specil	AD . Sex 7. Age 7. Age 1	77 Y 10c. City, Town MOI iver in U.S. 0 16a. E	Months Deys or Location NKTON 10f. Zip Code 21 13. Wes Decedent of If Yes, specify Cut 1 Yes, specify Cut 1 Yes, 2 No Decedent's Usuel Occur Give kind of work done ife. DO NOT use retire DFESSOR O	MONKTC If Under 24 Hrs. Hours Min. 111 Hispanic Origin? (Span, Mexican, Puerto Specify: pation during most of worked) IF BIOCHI 18. Mother's Nem	NOV . ocation of Deeth ON 8. Dete of Birth (Month, Day, O 5 / 1 8 / occity Yes or No- Rican, etc.)	20 2000 4c. County of Deet BALTII Year) 1923 9. Bin Co NEI 1923 NEI 14. Race - Ame Bleck, Whit Specify: Will 6b. Kind of Business/	MORE hplace (State or Foreign unity) WYORK 10d. Inside City Limits 1 □ Yes 2 No unity? rican Indien, e, etc. HITE Industry
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21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility HENRY W JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212 Approximate service, or one taleure. It is to right of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or one taleure. It is to right of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or one taleure. It is not one taleure in the mode of dying, such as cardiac or respiratory errest, or one taleure. It is not of the cause of one each line. Due to (or as a consequence of):			(v)				1/22/20	000 BALTO	O. MD.
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Due to (or es a consequence of):		William	lacell	_	4905 YOR	K RD. BA	LTO. MI	21212	
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27. Menner of Death 1 Directurel 2 Accident 3 Suicide 4 Homloide 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describ	9		Hospitet: 1 ☐ Inpatier	nt 2 ER/Outp	eatient 3 DOA	ther: 4 Nursing H	ome 5 PAeside	nce 6 Other (Spe	ocify)
29a. Certifler (Check only one) 1 Gertifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 29b. Signeture and fittle of certifer 29c. License number 29c. License number 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) STUART BELL M.D. 200 EAST 33RD STREET SUITE 650 BALTO., MD 21218.		1 DeNeturel 5 Pending	(Month, Dey				28d. Describe ho	w injury occurred	3/81/4
29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 29b. Signeture and fittle of certifer 29b. Signeture and fittle of certifer 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) STUART BELL M.D. 200 EAST 33RD STREET SUITE 650 BALTO., MD 21218.	Sertific	dotormino	286. Piece of inju	ry - At home, ferr (Specify)	n, street, fectory, office		28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,
29b. Signeture and fitte of certifier 29b. Signeture and fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. Licen	29	(Check only 2 Medical Exa	miner: On the basis of	examinetion end					
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) STUART BELL M.D. 200 EAST 33RD STREET SUITE 650 BALTO., MD 21218.			and manner stat	eu.	29c 1 icer	se number	26	ed. Date signed (More	h. Day, Yeari
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STUART BELL M.D. 200 EAST 33RD STREET SUITE 650 BALTO., MD 21218.		/1/6	see C	(11)	1)6	170	/ 1	11210	U
100 2.00 STREET SOITE 050 BABTO: MD 21210;	-				ype, Print)				
	S	STUART BELL M	.D. 200 H	EAST 33	RD STREE	T SUITE	650 BAI	LTO.,MD 2	21218.

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 37005 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 600 AM GOINES Geraldme L. November 19 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner Baltimore
Hunder 24 Hrs. 8. Data of Bi
Hours Min. (Month, D. Manor Nursing Home If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (in yrs. last birthday) **Funeral** 10 M 20 F 219-38-275 Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show trsumatic event, the Medical Examiner must be notified at 1 PYes 2 No Director Manyland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 21213 U.S. A Washington St. 210 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Item any Injury or other treumatic event, the Medical Examples. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: à Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Aide Nursing Nursing 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Parker UNKNOWN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 2724 Fish Road Balt. MD 21225 Bryant Comes 15on 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 11/21/2000 4 ☐ Donetion 5 ☐ Other (Specify) ay view Crematory, Irc. 22. Name and Address of Facility
Havi P. Close Formeral Sewice, P. A. 21. Signetura of Funeral Service Licensee MD 21201-1925 St., Balt. 709 Tessier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediate Cause (Finel disaese or condition resulting in death) /Medical weeks Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760 Physician/Medical 2 Due to (or as e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Cirues þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Wes casa referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 XNo To 27. Menner of Death
1 Netural
2 Accident 28c. Injury at Work? 28d. Describe how injury occurred e Hospităl or Atlanding Pi n'24 fours after death. 16 Funeral Director: After f Certification: 5 Pending investigation 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edical 29e. Certifier 10 4Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) Tothe To the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier. D-40521 November 21, 2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 7845 Ochwood R DR. OCHANES Stan Burnia, MD Road Suite 205 21061 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State NOV 2 2 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene

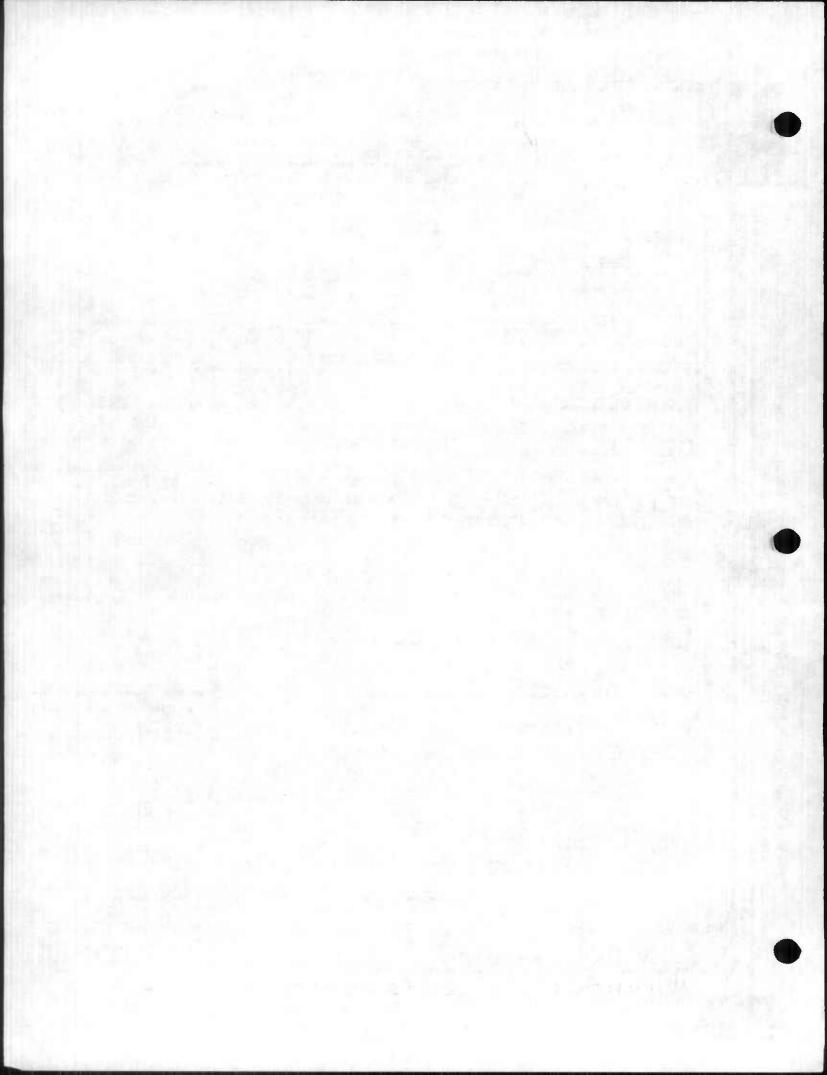
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					Cer	tificate o	f Dea	ith		Reg. No.			
		1. Decedent's Neme (First, Middle, La	st)						2. Date of De Month	eath Day	Yea		Time of Death
Physici	_	Charles G.	Haegerich	, Sr.					Nov.	16			:32PM
/Medic Examin	_	4a Facility Name (Il not institution, giv					4b. City	y, Town, or L	ocation of Deal		County of De		
E E Admini		North Arunde	1 Hospital				Gler	n Bur	nie	Ar	ne A	rund	o 1
Eumaral		5. Social Security Number 6. 5	-	yrs. last birt	thday)	If Under 1 Ye	er If Un	nder 24 Hrs.	8. Dete of Bi	rth			State or Foreign
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20 sher death with the Maryla or Nems 23s or 28s-f shor miner must be notified at	Funeral	11. Marital Status	12. Wes Decedent Ever	in U.S.	13. V	211 Vas Decedent d		c Orlgin? (Sp	ecify Yes or N		ed S		dien,
ler o	5	1 Never Married ** Never Married	Armed Forces? 1 ☐ Yes 2 ☑ No	., ., .,	If	Yes, specify C	uban, Me	xican, Puerto	Rican, etc.)		Bleck, WI	nite, etc.	
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Maryland 21215-0020 td 2 should be liked within 72 hours at the and Mental Hyglenn. T's marked other than "natural", or traumatic event, the Medical Exam.		17. Father's Neme (First, Middle, Last		1 3	up	ervisi		fother's Nam	e (First, Middle		pper	S	
and	Be o	Charles P. Had											
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Man in an in		19a. Informant's Neme/Relationship (
N. M. S. S.		Bruce Haegerie				Queen sition (Name of		≥ Roa					
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Pa Pa		4 ☐ Donation 5 ☐ Other (Special	The second secon	len :	Hav	ren Mei	n. P	ark 1	1/20/	00 G	len E	Burni	e, MD
and day		21. Signeture of Funeral Service Lice		-0	22.	. Name end Ad	dress of F	acilityGor	ice Fu	nera	1 Hom	ie, F	.A.
0 82188		MANAM	May	- Vo		001 Ri							
		23a. Pert1. Enter the disease, or com shock, or heert failure. List only	plications thet caused the	death. Do r	not ente	er the mode of	dying, such	h as cardiec	or respiretory	arrest,		Appr	oximate
Physician		shock, or heert failure. List only	one cause-on each line.	0								Onse	vai Between et and Deeth
/Medical		Immediate Cause (Final	3.										
Examiner		disease or condition resulting in death)	a	ryth				_				Min	utes
	5			to (or as e		277.00						1	
nsit ned	Examiner		b. Athros				iova	scula	r Dis	ease		12 y	rears
and and	xa	Sequentially list conditions, if any, leeding to immediate	Due	to (or es e	conseq	uence of):						t t	
X 68760, ertificate be executed ling physician and se as the burial-transit	100	cause. Enter Underlying Cause (Disease or Injury thet initieted events	c										
cate cate	edical	resulting in death) Last	Due	to (or as a c	onsequ	uence of):							
OX 6	Me		d									1	
death certification of for use es	lan												
. 0 0 %	Physician	Pert II, Other significant conditions of	ontributing to death but no	ot resulting In	the un	nderlying cause	given in F	Part I.	23b. Dic	tobacco i	use contrib	uta to the	cause of death?
P.O. that the detache	F	Hypertension							10	Yes 25	XNo 3□	Probably	4 Unknow
S & S &	by												
COrdS requires been sign should be	Completed	Chronic Ren	al Failure							s en eutop	sy 24	availeble	topsy findings prior to
25 8 60	pie										2.4	of death	ion of cause ?
The in	E O	Diverticulo	sis						10	Yes X	XNo	1 ☐ Yes	No No
	Be C	25. Wes case referred to medical	515				26. 1	Plece of Dee	th (Check only	one)			
	To B	examiner? 1 ☐ Yes 2 ② No	Hospital:	2 ER/Ou	toatien	t 3□ DOA	Other:		ome 5 Res		Other (S	pecify)	
		27. Manner of Death	28e. Date of Injury	28b. 1	Time of		njury at Work?		28d. Describe			p.coyy	
Oll ding in After funer	tion	1 Naturef 5 Pending 2 Accident Investigatio	(Month, Day Ye	ar) li	njury		Work? I ☐ Yes	2□No					
Division or Attending after death. Director: After	fica	3 ☐ Suicide 6 ☐ Could not b	OB Dises of Injury	At home, fe	rm. stre	eet, fectory, offi	CB		28f. Location	(Street and	d Number or	Rural Rou	rte Number,
OIVISI or Attendant after death Director:	Certification:	4 ☐ Homicide determined	building, etc. (S		,					own, State)			
prai i		200 Codifies 1 (Frontitude Di	and stars. To the best of me	. Innerela des	death	and at the	s times and a	to and place	and due to the	(0)		an stated	
To the Hospital of within 24 hours a To the Funeral Dempleral Lines	odical	29e. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of my miner: On the basis of exa	mination and	d/or inv	restigation, in m	y opinion,	, death occur	rred et the time	, date and	place, and	due to the	cause(s)
Pin and	× ×		and manner stated.			200 Lin	ense num	her		29d Date	e signed (Mo	ooth Dav	Year)
5 × 5 8		29b. Signature and title of certifier											
, \		11/1/92	July			D2.	1703			Nov	. 17,	200	00
1/1		30. Neme and address of person whe	completed cause of potth					0	0				
		Michael F. Garav	M. m.D/ 8	651 F	f	Smallw	ord	Rd F	usade	nce.	no	2112	1
Sta	te	31. Dete filed (Month, Day, Year)	32. Registrer's	Signeture							74		

DHMH 16 Rev 6/95

Registrar

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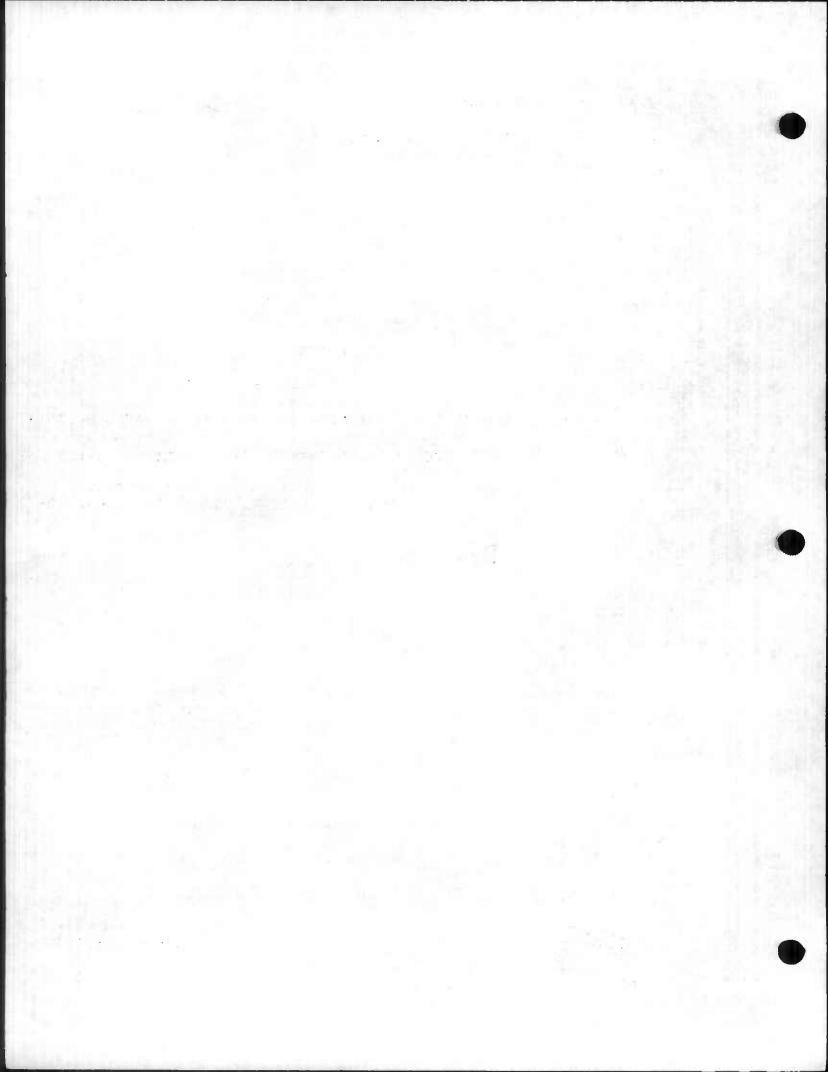
partment of Health and Mental Hygiene	00	3
No. of Co. of Co		

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Tima of Death Dey Month Year **Physician JEAN** M. HARRISON NOVEMBER 15,2000 6:15 pm /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROLAND PARK PLACE (HEALTH CARE CEN.) BALTIMORE N/A 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (Stata or Foraign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 MX 2 F 132-01-9130 Director 81 06-26-1919 NEW YORK Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits must be notified at MD. N/A BALTIMORE CITY Director XIX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23s or 830 WEST 40th. STREET 21211 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 ☐ Yes XXNo 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes XX No Specify: Specify: WHITE þ Year or Detes: Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) the Medical 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) Coilege (1-4or 5+) OWN HOME HOUSEWIFE 12 YEARS 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middla, Last) Be Pages 1 and 2 should be sent of Health and Mental married DAVID McPHERSON SARAH SINCLAIR 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) . NANCY B. HARRISON (DAUGH.) 9 BIEHL COURT, OWNINGS MILLS, MARYLAND, 21117 Department of Health reportant: If Nem 27 20b. Piace of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XXCremetion 3 ☐ Removel from Stete GREEN MOUNT CREMATORY 11-17 BALTIMORE, MD. 21202 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY ∇ - 4 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Finel disease or condition resulting in deeth) /Medical 5 years ementia Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): attending p signed by the a Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ should I 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an eutopsy cartificate has b 1 Yes XX No 1 Yes XX No or Attending Physician: after death. Director: After this cartifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitei: Other: 4 Nursing Homey Residence 6 Other (Specify) 10 1 Yes XX No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Panding investigation XXNatural 1 Yes 2 No octor: A 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a, Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D33897 -,MP NOVEMBER 16,2000 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) 3509 Eastern Ave Baltimore MD VISSING, M.D., ROBERT J. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 Registrar

DHMH 16 Rev 6/95

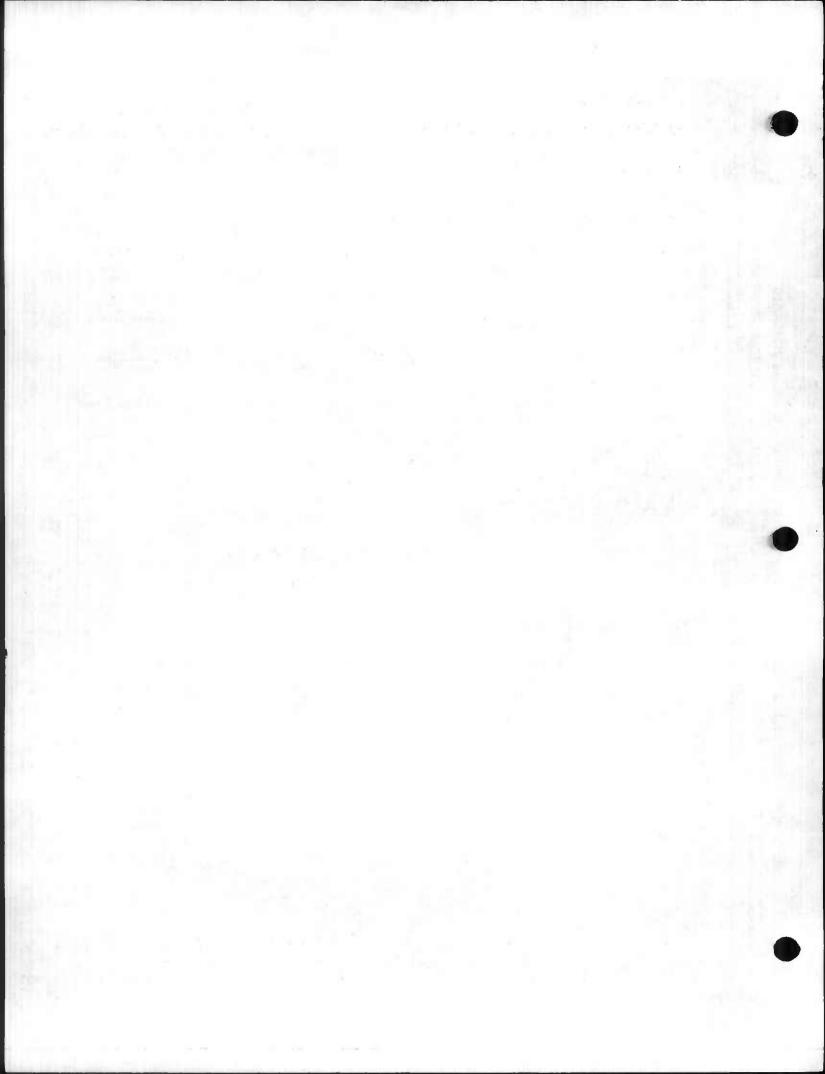
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

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						Cer	tificate of	Death		Reg. No.		0,000
	Phys	ician	1. Decedent's Neme (First, Middle, L.						2. Date of D	eath Day	Year	3. Time of Death
		dical	MILDRED M. HAGOO			_			MOYEN	MBER 2	1 200	09:408.
	Exam	niner	4a Facility Name (If not institution, gi	MDEL F	10sp.	ITY			BURN	de An	of Death	ARUNDEL
ue	Funera Directo	_	215-86-2126	Sex 1□ M 2ÅF	e (In yrs. lasi 78	t birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D MARCH	rth ay. Year) 2, 1922	Count	
	pu .		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, T	Town or Lo	cation				10	Od. Inside City Limits
ED	ith with the Merylan 23a or 28a-f show	Director	MARYLAND ANNE AR	UNDEL	SEVER		RK		,			1 ☐ Yes 2 Ñ No
8	deeth with the Menyland ma 23a or 28a-f show Fritael be notified at		10e. Street and Number 674 BENFIELD RD.				10f. Zip Code 21146			10g. Citizen of V UNITED		•
075	21215-0020 d within 72 hours efter dee giene. r than "netural", or itema	by Funeral	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Detes:	Ever in U,S. No	H	Vas Decedent of Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		e - America ck, White, e	etc.
H	5-0 72 ho	ted	15. Decedent's E (Specify only highest gr	ducation	1	6a. Deced	ent's Usual Occu	pation during most of work	kina	16b. Kind of Br	usiness/Ind	ustry
5	121	Completed	Elementery/Secondery (0-12)	College (1-4or 5	5+)	life. D	OO NOT use retin	ed)	· · · · · ·	OLDI 110	ME	
	d 2121 filed within thygiene. ther then	S	17. Father's Neme (First, Middle, Las	n		HOMEM	IAKEK	18. Mother's Nam	a /Eiret Middle	OWN HO		
OD	yland build be t Mentel I arked of	To Be	WILLIAM MANNING	,				LILLIAN		i, maioeri Surrian	10)	
000	Mar and 2 sh saith and 27 is m		19a. Informent's Neme/Reletionship WILLIAM G. HAGOO					RD., SEVI				
HAG	Baltimore, Maryland 212. permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the M.		20e. Method of Disposition 1 △ Byrial 2 □ Cremetion 3 □ 4 □ Denetion 5 □ Other (Special Contents)	Removel from State	Cern	etery, crem	sition (Name of natory or other ple		NOV. 24 2000	20c. Location -		m, State MARYLAND
I	Balt permit. Depart Import any Inj	SUC.	21. Signeture of Fuberal Service Lice	l		KI		UDDICK FULL HWY., S.I				21061
	Physician /Medica Examine	il r	23a. Pert1. Enfer the disease, or conshock, or heer feilure. List only Immediate Cause (Final disease or condition resulting in deeth)			AT	ORY	ARRI		2100		Onset and Death
	I Records, P.O. Box 68760, The lew requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	N/Medical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c. 5E	Due to (or es	TS						
	is that the death celigned by the attendif	Physician	Part II. Other significant conditions	contributing to death be	ut not resultir	ng in the un	derlying cause g	iven in Pert I.		tobecco use co	ntribute to	the cause of death?
	Division of Vital Records, I or Attanding Physician: The lew requires the start death. Director: After this certificate has been signed in by the funeral director, page 2 should be de	Completed by I							24a. Wa: peri	an autopsy ormed?	ave	ore eutopsy findings sitable prior to npletion of cause seath?
	I Re lev ate has page 2	dwo							10	Yes 200No		Yes 2500
	Vital I	BeC	25. Wes case referred to medical					26. Place of Dea				7165 25410
	of Vita Physician: this certific	To B	exeminer? 1 Yes 2 No	Hospitel:	nt 2 ER	/Outpatient	3 DOA O	hor		idence 6 Oth	er (Specifi	1)
	Attending Physic death.	atlon:	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Dete of Inju (Month, De		b. Time of Injury	28c. Inju Wo	ıryat ork?]Yes 2∐No	28d. Describe	how injury occur	red	
	Division attending a star death i Director: A d in by the f	Certification:	3 Suicide 6 Could not be determined		ury - At home c. (Specify)	, farm, stre	et, fectory, office		28f. Location City or To	(Street and Numb wn, State)	er or Rurai	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai C	29a. Certifier 1 Certifying Pr (Check only one) 1 Medical Example 1	nysician: To the best of miner: On the besis of and manner ste	examination	dge, death and/or inv	occurred at the t estigation, in my	ime, date and place, opinion, death occur	, and due to the rred at the time	cause(s) and me date and place,	unner as str and due to	ated. the cause(s)
	To the comp	Me	29b. Signeture end title of certifier	WYX	32	m	D 29c. Licen	ise number 4		29d. Dete signe		
	2 10)	30, Neme and address of person who	completed cause of d	eath (Item 23	(Type. 5	TO HOUS	TTALD	TYE	BLEN	那是	WIE MD
	S Regis	tate trar	31. Dete filed (Month, Day, Year) NOV 2 2 200		er's Signeture	B.	Loan	2				21067



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Yaar 8'00 am 17 2000 IOLA VOV Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Health BEL lariner HARFORD If Undar 24 Hrs. If Undar 1 Yaar 8. Data of Birth (Month, Day, 9. Birthplace (Stata or Foreign Country) ARY A CO 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Months Days Hours 1□M 28 F 14 1962 93 JULY 31, 1907 Usual Rasidance of Decedant 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ☐ Yas 2 No HARFORD MARALAMO 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? PHAIL KOAC D.S.A 2A3 014 41016 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar In U.S. Armed Forcas? 11. Marital Status 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Navar Married 2 Married 1 Yas 2 No Specify: STIHW 3™ Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) College (1-4or 5+) Elamantary/Secondary (0-12) BANK ELERK BANKING 124185-17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) SZUAHUZZA MARY AND AYRES NHOL 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 21015 1939 EVPRUS (70AO DAVID W-LoopER Date 20c. Location - City or Town, Stata Nov.20 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State MRKVILL 4 □Donation 5 □Othar (Specify) KW000 LEMETERY 1ARYLAND 21. Signature of Funeral Service Licentage 22. Nama and Addrass of Facility EVAN FURRAL CHAPIL-BUL RIR, P.A 3 NEWPORT DRIVE FORSET HILL 23a. Part1. Entar tha disaasa, or complicate shock, or heart failure. List only one complete the shock of the High is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Urosepsis 10 days Immediata Causa (Final disaasa or condition resulting in death) Dua to (or as a consequenca of) Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 2 No 1 Yas 1 ☐ Yas 2 ☐ No 26. Place of Daath (Chack only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

reportant: If item 27 is my injury or other

permit. Pege Department of Important: If any injury or once.

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

Funeral

Director

the Meryland

Peges 1 and 2 should be filed within 72 hours after death with the Merylan nent of Health end Mentel Hygiane. Int: If item 27 is marked other than "natural", or items 23s or 28s-f show ary or other traumatic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0020

Examiner physicien end tha buriel-transit Physician/Medical 98 esn þ Completed Be 10 Certification:

that the death certificate be executed s certificate has been signed by tha e director, paga 2 should be deteched for After this funeral after deeth

To the Hospital or within 24 hours aft To the Funeral Di completaly filled in edical 25. Was casa referred to medical 1 Yas 2 No 27. Manner of Deeth 1 Natural 2 Accident 3 Suicida 4 \ Homicide

29a. Certifier

5 Panding Invastigation

6 Could not be datamined

28a. Data of Injury (Month, Day Year) 28b. Tima of

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how Injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifiar

31. Data filed (Month, Day, Year) NOV 2 2 2000

29c. Licansa number 34652

28c. Injury at Work?

1 Yas

2 No

29d. Date signed (Month, Day, Year) November 17, 2000

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) North Avenue HASWIN

Bil Air Maryland 21014

State Registrar 32. Ragistrar's Signatura

MORNING BELLION Command Art Jan S. A. Thy selection.

Please T

3 Time of Death

ype or Print in Black Indelible Ink. Assure A	II Copies Are Legible.
State of Maryland / Department of Health and I	Mental Hygiene
Certificate of Death	Reg. No.
	Dote of Death

Physician /Medical Examiner

1. Decedent's Nama (First, Middla, Last)

GERTRUDE

218 22 7336

10b. County

112 North Bend Terrace

Usual Residence of Deceden

10a. State

Director

Maryland

10e. Street end Number

Director

Nems 23a or 28a-f show the Medical Examiner must be notified natural, or

filed within 72 hours after should be Mental and and Pages 1 and 2 f Health Bern 27 i 8

Funeral 12. Was Dacedent Evar in U,S Armed Forces? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 1 Yes 2 No If Yas, Giva Year or Datas: 1 Never Married 2 Merried Maryland 21215-0020 1 ☐ Yas 2 No Specify. þ 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) Elemantary/Secondary (0-12) Collega (1-4or 5+) Office Worker 12th 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Fathar's Nama (First, Middla, Last) George Baker 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Son 302 Chalet Drive John Hopple Jr. Baltimore, 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 21. Sign unit of Funeral Service Licensee 22. Nama and Addrass of Facility ations that caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory errast, a cause on each line. Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) . INTRACEREBRAL BLEED Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events Dua to (or as a consequance of): and 68760. that initiated events rasulting in death) Last Due to (or as e consaguança of): use as the Box (P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by should be Dage 2 1 ☐ Yas To the Hospital or Attending Physician: within 24 hours after death.

In the Funeral Director: After this certifica 25. Was case rafarred to medical examinar? 26. Placa of Death (Check only one) Hospital: 1 Departiant 212 No Medical Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Tima of Injury at Work? Division 5 Panding invastigation Natural Injury 1 ☐ Yas 2 ☐ No 2 Accidant the 3 Suicida 6 Could not be datamined 28a. Placa of Injury - At home, farm, straat, factory, offica building, etc. (Specify) filled in by 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Cartifier the etely FIRST YEAR 29c. Licansa number 29b. Signeture end titla of certifian P13127 RESIDENT son who completed cause of death (Itam 23a) (Type, Print) MOHAMMED

DORTHY

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Yrs

10c. City, Town or Location

Glen Burnie

1 M 20 F

Anne Arundel

HOPPLE 1:15AM NOVEMBER, 17, 2000 ocation of Death 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE N/A Birthplace (State or Foreign Country) Months Days Maryland 10d. Inside City Limits 1 Yas 2 No 10f, Zip Code 10g. Citizan of What Country? 21060 U.S. Raca - Amarican Indien, Black, White, atc. Specify: White 16b. Kind of Business/Industry M.V.A.

Eleanor Schilling

Millersville, Maryland 21108 20c. Location - City or Town, Stata

11/20/00 Baltimore, Maryland

Gonce Funeral Home P.A. 21225

Approximata Interval Batwaan Onset and Daath

THREE DAYS

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wera autopsy findings available prior to complation of causa of daath? 24 No 1 □ Yas 2 □ No

Othar: 4 Nursing Home 5 Rasidance 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

21225 NOVER STREET BALTIMORE, MD

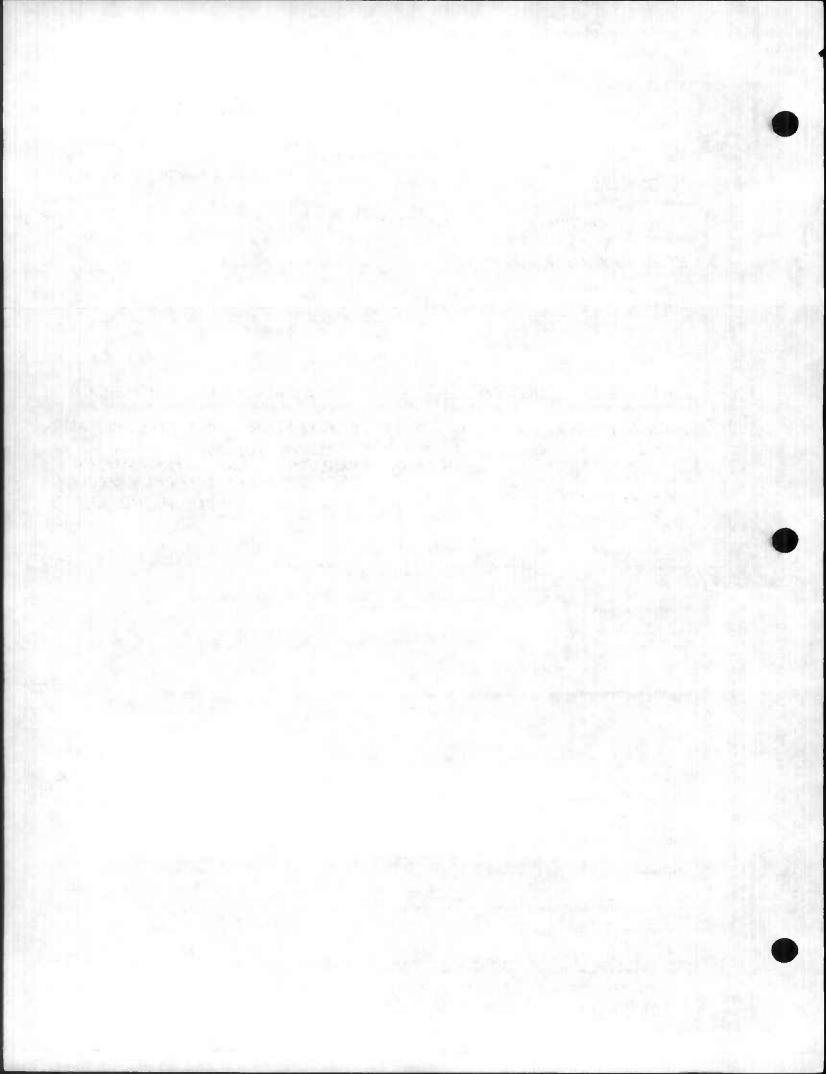
State NOV Registrar

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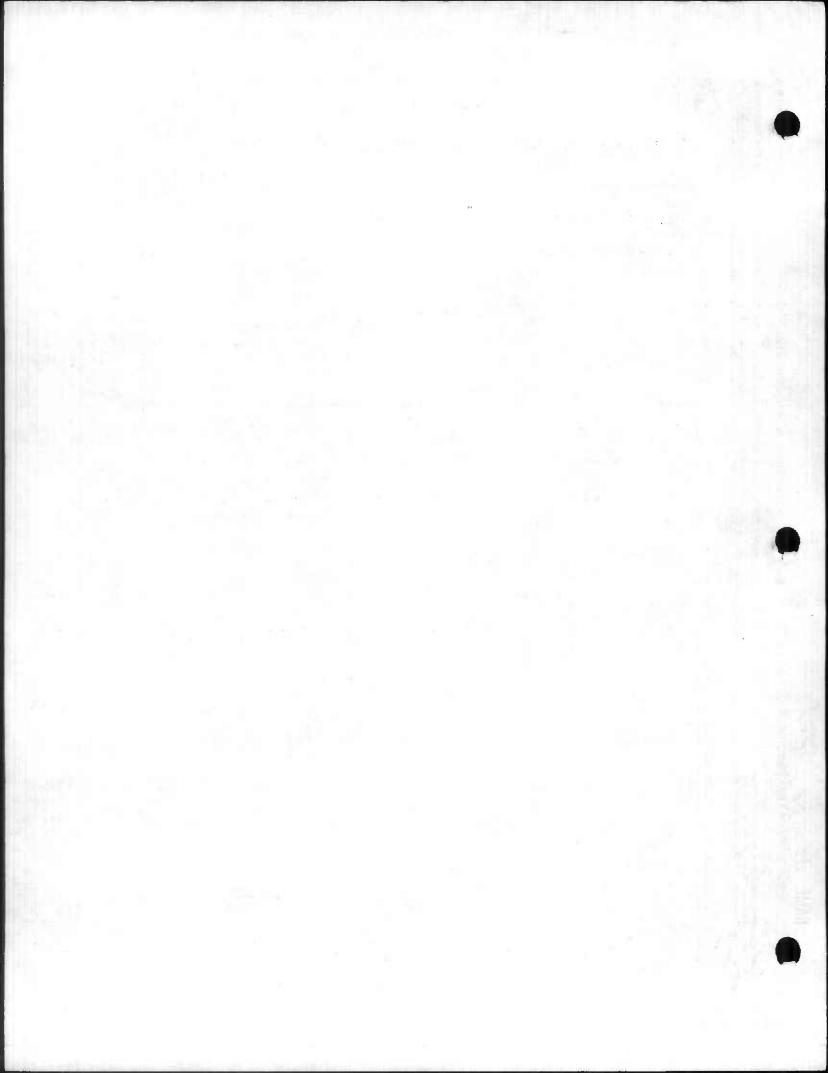
State of Maryland / Department of Health and Mental Hygiene 370

			Certific	ate of Death	Re	g. No.	0,011
Dhorisian	1. Decedent's Neme (First, Middle, Las	st)			2. Dete of Deeth Month	Dev Yes	3. Time of Death
Physician /Medical			OUSTON	4h City Town or	NOV.	17 2000	12:40 AH
Examiner	4a Facility Name (If not institution, give					4c. County of De	
	5. Social Security Number 6. Se			TOWSO	B Date of Birth	0.5	TIMORE Sixtholaga (State or Foreign
Funeral Director		ØM 20F 69	Yrs. Mor	ths Deys Hours Min	(Month, Dey,	Year) 1930 PE	Birthplace (State or Foreign Country) NNSYLVANIA
ð u	10a. State 10b. County	10c.	City, Town or Location				10d. Inside City Limits
the property	MD BALTIMA	ORE P	ARKTON				1□ Yes 2☑No
ire in	10e. Street and Number			. Zip Code	10	g. Citizen of What	Country?
al B	506 RAVEN	ROCK CT		21120		U.S	A -
Examiner must be notified by Funeral Director	11. Merital Stetus 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	1□ ∀	ecedent of Hispenic Origin? (s specify Cuben, Mexican, Puel as 2 No Specify:	Specify Yes or No- rto Rican, etc.)	Black, W	
	3 ☑ Widowed 4 □ Divorced	Year or Detes: KOR		Usual Casarastica			WHITE
t, the Medical Completed	15. Decedent's Ed (Specify only highest grad Elementery/Secondery (0-12)	College (1-4or 5+)	(Give kind o	Usuel Occupation If work done during most of wo Truse retired)	orking	6b. Kind of Busine	. F. E.
Contract	17. Father's Neme (First, Middle, Last)		The state of the s	18. Mother's Na	me (First, Middle, N		. 4-0.
o Be	ALOUISUS	HOUSTON			NM.		EILIA
F	19e. tnformant's Name/Reletionship (7		19b. Meiling Add	Iress (Street end Number or R			
27 18	VICTORIA REEVES	. DAUGHTER.	3049	MAN FORFST	NP PAR	VIIIIE	NV 7173A
othe	20a. Method of Disposition	200	. Place of Disposition cemetery, cremetory	and the same of th	Dete 2	Oc. Location - City	or Town, State
# 5 5	1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specify			EMETERY	1000 JON	PARKILL	F MD
and a	21. Signature of Fyneral Service Licen				VANS FUI		
168	V form Sul	400	17.18				
	23a. Part. Enter the disease or come	olications that saused the de	eeth. Do not enter the	mode of dying, such es cardia	ac or respiretory erre	IUM, MC	Approximete
sician	phock, or heart failure. List only	one cause of each line.					Onset end Death
dical	Immediate Cause (Finel disease or condition	C 11	Cell Lo	0- 0-			1 4
iner	resulting in death)		(or es e consequence	ing Cancer			MONTHS
ne ne	14.00			,,,			
edical Examiner	Sequentially list conditions,	b	(or es e consequence	of):			
EX I	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						W 100
	that initieted events resulting in death) Last	Due to	(or es e consequence	of):			
4		d					
I for use							
etached for use Physician/N	Pert It. Other significant conditions co	ontributing to death but not r	resulting in the underly	ing cause given in Pert t.	23b. Dld to	bacco use contrib	ute to the cause of death?
detac					150	s 2□ No 3□	Probably 4 Unknown
Completed by Physic		To be			24e. Was er perform		b. Were autopsy findings aveilable prior to completion of cause
mp					All rother		of deeth?
8 00					1 ☐ Ye		1 ☐ Yes 2.5 No
director, page 2 s	25. Was case referred to medical examiner?	Hospitel:		Other	eeth (Check only on		w. (do Co.)
- I	1 Yes 2 No 27. Menner of Death	1 ☐ Inpatient 2	☐ ER/Outpetient 3☐ 28b. Time of	J DOA 4LJ Nursing	Home 5 Heside		ipecity) (toSpice
d in by the funericertification:	1 Netural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	28c. Injury et Work? 1 Yes 2 No		,,	
£ 3	3 Suicide 6 Could not be 4 Homicide determined		t home, ferm, street, fe	octory, office	28f. Location (St. City or Town	reet end Number or , Stete)	r Rural Route Number,
completely filled in Medical Cert	29e. Certifier Check only 2 Medical Exam	ysician: To the best of my k liner: On the basis of exami end menner steted.	nowledge, deeth occu inetion end/or investige	rred et the time, date end plec etion, in my opinion, death occ	ea, end due to the ce curred et the time, da	ouse(s) end menne ate end placa, and o	r es stated. dua to the cause(s)
To the Funeral D completely filled i	29b. Signature and little of certifier	0		29c. License number		d. Date signed (Me	
	De dia M	(0,00)	MD	0005192	6	You. 17	2000
7	30. Name and address of person who o	completed cause of death (II	tem 23a) (Type, Print))
0	6601 N. Char	les St, Balti	nove my	0005192 21204 Hel	ien M.C	pordon	
State	NOV 2 2 7000	32. Registrar's Sig	por por	NS.			



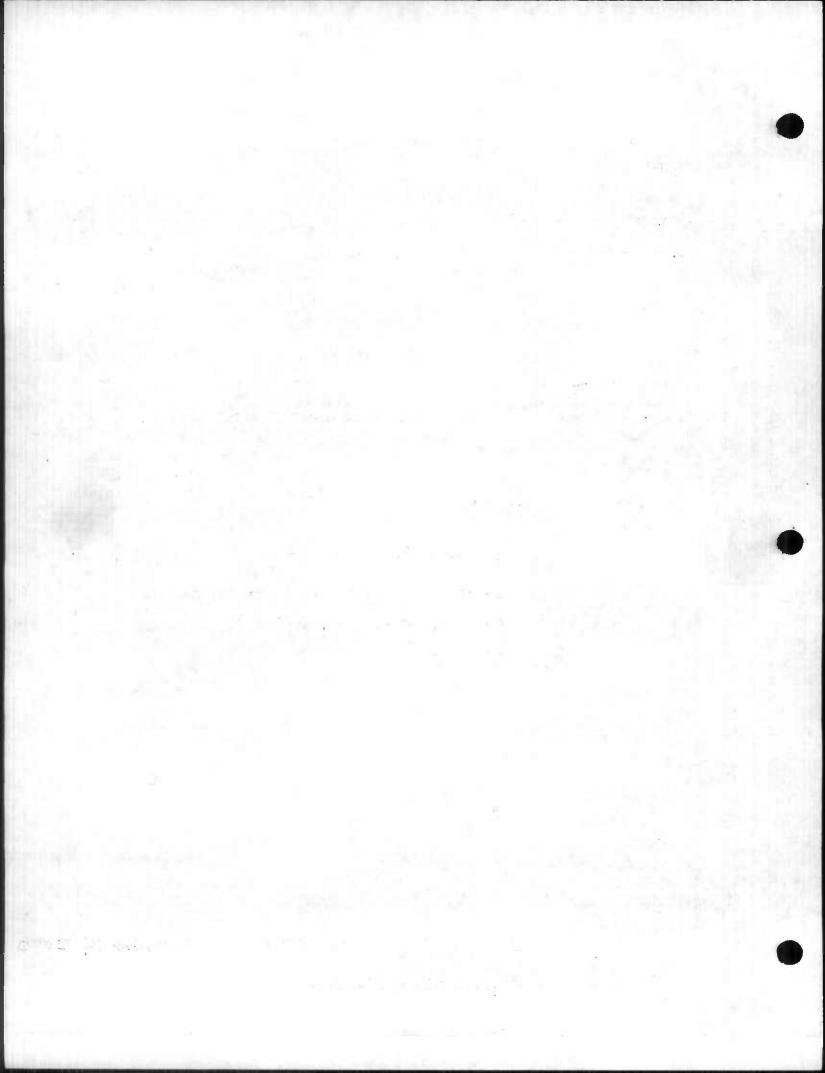
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 370 2 Certificate of Death Reg. No. 2. Date of Death 3. Tima of Deetl

			C	ertificate	e of l	Jeath		Re	g. No.			
sician	Decedent's Nama (First, Middle, L.		ouston Jes	see Si	r.			Date of Death Month	Day	Year	3. Tima of D	Deeth
dical	4a Facility Name (If not institution, gi					b. City. Tow	-	tion of Death	4c. County		1:30	71-
miner	ST. AGNES HO	EALTH CA	RE	(v) If Under		BALTI.	MOR	E		N/A		
ral or		Sex 7. Age 1XIM 2□ F	66 Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day, OV • 9,	Year) 1934	Coun	lace (State or try) ginia	Foreign
irector	10a. State 10b. County		10c. City, Town or	Location						10	od. Inside City	Limits
ctor	Maryland Balti	more	Lans	downe							1□Yes 2	2X) No
al Directo	10a. Street and Number 804 - Fifth Ave	nue		10f. Zīp	Code 2122	7		10	g. Citizen of U		try?	
by Funeral	11. Merital Status 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 11 Yes 2 N If Yes, Give Year or Dates:	verin U,S. 13 Korean Conflict	Was Deced If Yes, spec		ispanic Origi n, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)		ce - America ck, White, o		
eted	15. Decedent's E (Specify only highest gr	ducation	16a. Dec	edent's Usua re kind of wor	rk done d	durina most d	of working	1	6b. Kind of B	usinass/Ind	lustry	7
Completed	Elementary/Secondary (0-12) 9th	College (1-4or 5-	+)	uck Dr					H&S	Bake	ry	
Be	17. Father's Name (First, Middle, Las	1)		100		18. Mother's	s Name (F	irst, Middle, M	aiden Sumen	ne)		
To		Walter Luth	er Jessee	9			Ha1	lie May	Lamie			
(3.5)	19a. Informant's Neme/Reletionship	(Type, Print)	19b. Ma	iling Address	(Street	and Number	or Rural F	Route Number,	City or Town	State, Zip	Code)	
	Maria Jessee /	wife	804	Fifth	Ave	nue	Lan	sdowne,	Mary	and 2	21227	
	20a. Method of Disposition 1			ematory or or	ther plac	-		Dete 2 /17/00	Oc. Location			land
9008	21. Signeture of Funeral Service Lice			22. Name and	d Addres	ss of Fecility	G	once Fu	neral	Home	P.A.	Tario
***	Jerome)	namer	weeth 1	1001 Ri	itch:	ie Hig	hway	Balti	more,	Md. 2	21225	
ledical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. pn	per is but to (or as a constitution of the con	equence of):	9	Cance	er				day	s
Physician/N	Pert II. Other significant conditions	d	t not resulting in the	underlying co	ause div	en in Part t		23b. Did tot	acco uee co	entribute to	the cause of	death?
by Phys									• 2□No	3 Prot		Inknown
Completed b								24a. Wes an perform	autopsy ed?	ava	are autopsy fin allable prior to appletion of car deeth?	
EO.								1 ☐ Yes	2 10 No		Yes 200	,
Be	25. Wes case referred to medical					26. Place o	of Death /	Check only one)			
0	examiner? 1 Yes 2 Y No	Hospital: 1 Inpatier	nt 2 ER/Outpati	ent 3 DO	A Oth	or.		5 Resider		ner (Specifi	()	
tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day			8c. Injun Worl		280	d. Describe how			, 	13
Certification:	3 Suicide 6 Could not be determined	De Dines of Injur	ry - At home, farm, a (Specify)	street, factory	, office		281	Location (Str. City or Town,	eet and Numi Stete)	ber or Rura	l Route Numbe	er,
edical	29a. Certifier (Check only one)	hysician: To the best of miner: On the basis of and manner state	examination and/or	ath occurred a investigation,	at the tim in my of	e, date end pinion, death	place, end	due to the car at the time, da	use(s) and m te end place,	ennar as st and due to	ated. the cause(s)	
1 2	29b. Signeture and title of certifier			29c		number			d. Date signe		Dey, Year)	
	1 11 10	11	110		0	00 = 3	1510	1 1	- 10 h	1	11 00	200
1	30. Name and address of person who	9000	, M.D.		ν	0055	,5/	4 Naltimo	ovembe	1	4 20	



d Item#6 perINFG790 12/2	20/2000 EW	aryland / Dep	ertificate of			Reg. No.	
1. Decedent's Name (First, Michaelical	Idle, Lasi) JENSEI	N			2. Data of Do Month Novern	Day	Year 2000 5:41 PM
ner 4a Fecility Name (Il not institut Johns Hople)		Mekica		4b. City, Town, or L Balt	ocation of Deal	- '	of Death Itimere
5. Social Security Number 518–16–6465		81 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D. July 7	rth ay, Year) , 1919	9. Birthplace (State or Foreign Country) Idaho
Usual Residence of Decedent 10a. State 10b. Coun	ity	10c. City, Town or	Location				10d. Inside City Limits
Virginia	el lucco el	Arling	ton				Yas 2□No
1301 South Sco	tt Street #40	5	10f. Zip Code 22204			10g. Citizen of W	Vhat Country?
11. Marital Status 1 Never Married MM 3 Widowed 4 Divorce	12. Was Decedant E Armed Forces? 11 Yes 2 N	Evar in U,S. 13	. Was Decedent of I	an, Mexican, Puerto	pecify Yes or No Rican, etc.)	o- 14. Raci Blac	e - American Indian, k, White, etc. : White
	ent's Education hast grade completed)	16a. Dec	redent's Usual Occup ve kind of work done DO NOT use retire	pation during most of work	king	16b. Kind of Bu	siness/industry
15. Deced (Specify only high Elementary/Secondary (0-12		+)	. <i>DO NOT</i> use retire Enforceme:			State &	Federal Govt.
17. Father's Nama (First, Middl		Law	DITTOT CEME	T		a, Maiden Sumam	
Charles Emanue				Flora M		10	
19a. Informant's Name/Ralation Thelma 1. Jens			South Sco				State, Zip Code) VA 22204
20a. Mathod of Disposition 1 XBuriai 2 Crematio 4 Donation 5 Other	n 3 □Removal from State	20b. Placa of Dis	position (Name of ematory or other pla 1 Memoria	ice)	Date 12/01	20c. Location -	City or Town, Stata
21. Signature of Funeral Service	* *		22. Name and Addre	ess of Facility Na	tional	Funeral	Home
Thanda	L Lenn	rel_					Approximate
23a. Part 1. Entar tha diseasa, shock, or heart failure. L tmmediate Cause (Final disease or condition resulting in death) Sequentially tist conditions, if any, laading to immediate	pull b. Con	monary Due to (or as a cons	nemmeduence of):			9	Interval Between Onset and Death Smin 6 month
Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions.	4 .	Dua to (or as a consi Sepsis	curtery equance of):	disea	se	•	1 year 3 days
Part II. Other significant condi	itlone contributing to death bu	ut not resulting in the	underlying cause gi	ivan in Part I.		tobacco use con	ntribute to the cause of death? 3 Probably 4 Unknown
					24a. Wa	s an autopsy formed?	24b. Were autopsy findings available prior to completion of causa of death?
						Yas 20 No	1 Yes 2 No
65 Z LI NOCIOBILI	Hospital: 1 Inpatial 28a Data of Injur (Month, Day stigation	v 28b. Time	of 28c. Inju		ome 5 Res 28d. Describe	sidance 6 Oth how injury occurr	red
3 Suicida 6 Cou date	28e. Placa of Injubuilding, etc	ury - At home, farm, : c. (Specify)	street, factory, offica		281. Location City or To	(Street and Numb own, State)	er or Rural Route Number,
29a. Certifier 11 Certifi	ying Physician: To the best of al Examiner: On the basis of and manner sta	examination and/or					
29b. Signature and title of certi	fier B. Hali on who completed cause of de	MQ eath (Item 23a) (Typ	e, Print)	5001		29d. Date signe Novemb	d (Month, Day, Year) Ver 14 2000
State 31. Date filed (Month, Day, Yes	kins Bayvier	Wedice ar's Signature	el Center	2			
State strar NOV 2 2 7	2000 5	La fa	boards	/			
/95	1	, OI	RIGINAL				

cc



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Ricardo 9:58 am Jenning 2000 18 h /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Ritchie Hospice Baltimore 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) Funeral 1∏M 2□F Days Min Months Hours 213-80-9228 Yrs. 43 Director MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylai nant of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23s or 23s-f ahover yor other traumatic avant, the Hederal Emman must be notified as XXYes 2 No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1903 E. 29th Street 21218 USA Funeral 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11 Marital Status Black, Whita, etc. 1 Yas 2 No If Yes, Give X Yaar or Datas: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Traffic MD. St. Highway 12th Grade Assessor BA Degree 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be Theodore Jennings Mary Hall 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Mary Jennings 1903 E. 29th Street Baltimore, MD. 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cramation 3 ☐ Removal from State Greenmount Cemetery 11-25-2000 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility WM.C.March FH 1101 E. North Avenue
enter the mode of dying, such as cerdiac or respiratory arrest Warne 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final month Alino Carcinoma colon diseasa or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) USB BS Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the a 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown malnutrition 2 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed page 2 has 1 ☐ Yes 2 ☑No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Nespisa Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 2 this funaral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? After t Netural 5 Pending investigation 1 Tes 2 No 2 Accident aftar death Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 8 4 Homlcide Hospital 24 hours a Funeral D 29e. Certifier 1S Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated. edical completaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only one) To the To the To the 29b. Signature and the of partition 29c. Licanse number 29d. Data signed (Month, Day, Year) 11.19.2000 D41476 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) #416 6565 N. Chagles St 21204 WILSON M.D. Bullimore MD. RAYMOND W.

Registrar DHMH 16 Ray 6/95

31. Date filed (Month, Day, Year) 2000

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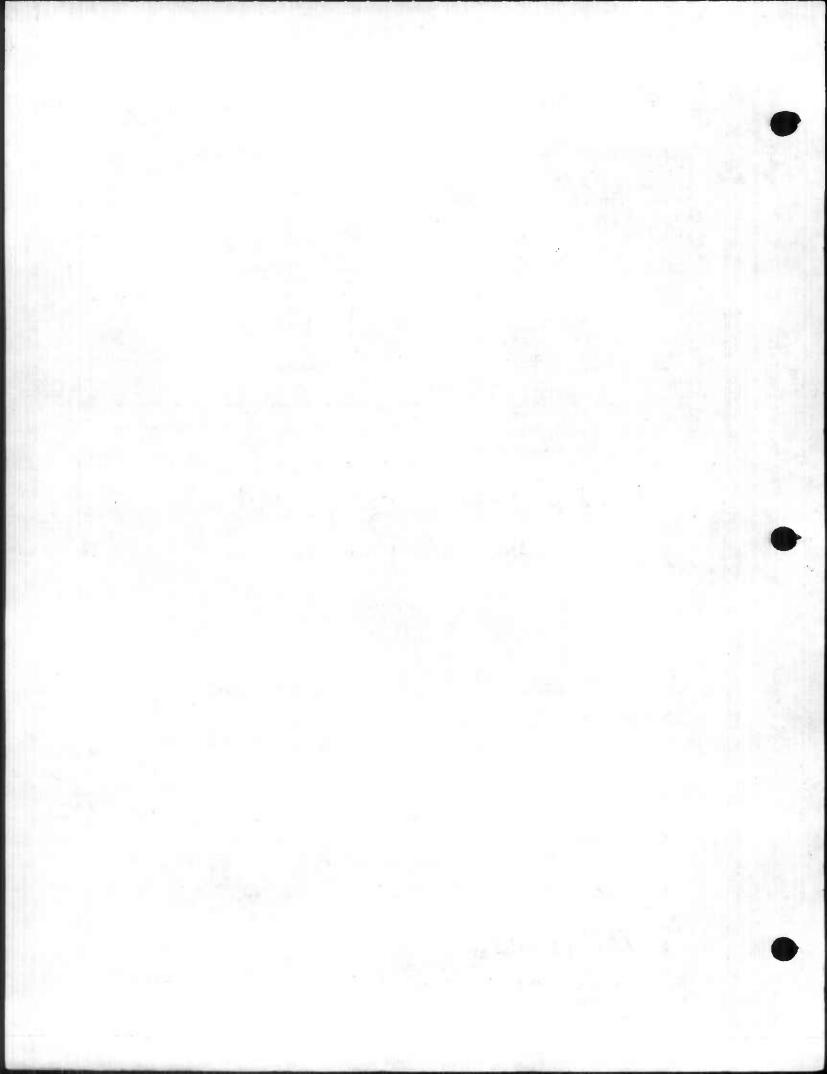
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JENNIDES

Richero

32 Registrar S Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Dev Month Von **Physician** Jack L. 16, 2000 Johnson 8:29 p.m. November /Medical 4e Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4511 Ten Oaks Road Dayton Howard 8. Dete of Birth (Month, Day, Year) If Under 24 Hrs Hours Min. If Under 1 Yaar 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days M 2□ F Months 71 Aug. 19, 1929 Director 228-20-9840 North Carolina Usual Residence of Decedan with the Maryland 10a, Stata 10b. County 10c. City. Town or Location 7 is marked other than "natural", or Itama 23a or 28a-f show trsumatic svent, the Medical Examinal must be notified at 10d. Inside City Limits 1 Yas X No Director Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4511 Ten Oaks Road 21036 USA filed within 72 hours after death hygiene. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indien, 11. Maritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White P 3√ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondary (0-12) 12 Cottege (1-4or 5+) Owner Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other treumatic event page. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) James F. Johnson Olia Blythe 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Jack Johnson, Jr./Son 12605 Franklin Farm Road, Oak Hill, Virginia 20171 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata *Burial 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) St. Louis Cemetery 11/20/00 Clarksville, Maryland 22. Name end Address of Facility Fleck Funeral Home, Inc. 21 Signature of Funaral Service Lice 7601 Sandy Spring Road, Laurel, Maryland 20707 or complications hat caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, ist only one cause on each line. 23a. Part . Enter the disea Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Due to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? as been signed by the 2 should be deteched Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause ot death? Completed 24e. Wes an eutopsy has page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Director; After this certilicated in by the funeral director, pag or Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ tnpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 2 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. tnjury et Work? Certification: Neturat 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 ☐ Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner as stated.

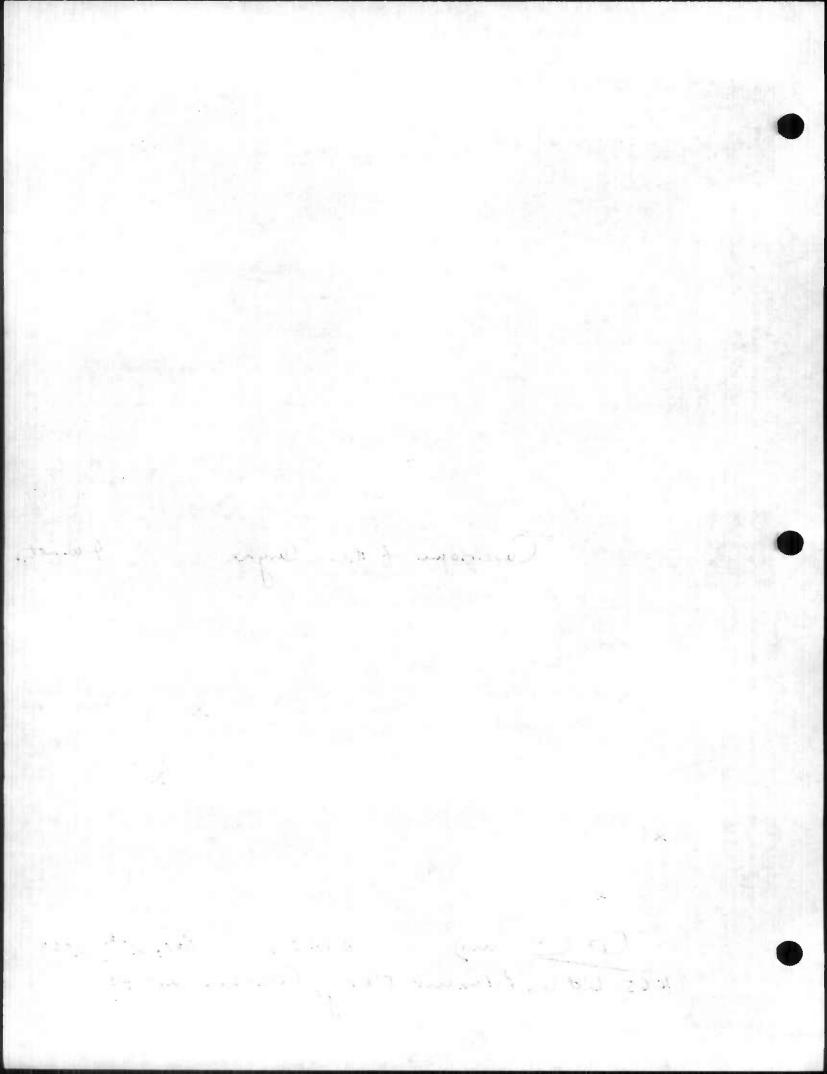
2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. edical 29e. Certifier 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifie 29c. License number 39 411 000 30. Name and address of person who completed cause of deeth (Item 23a) (Type Print) lumbia 11065 tux eur 31. Date fited (Month, Dey, Year) 32. Registrer's Signeture 2 2 2000 Registrar

ORIGINAL

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DHMH 16 Rev 6/95

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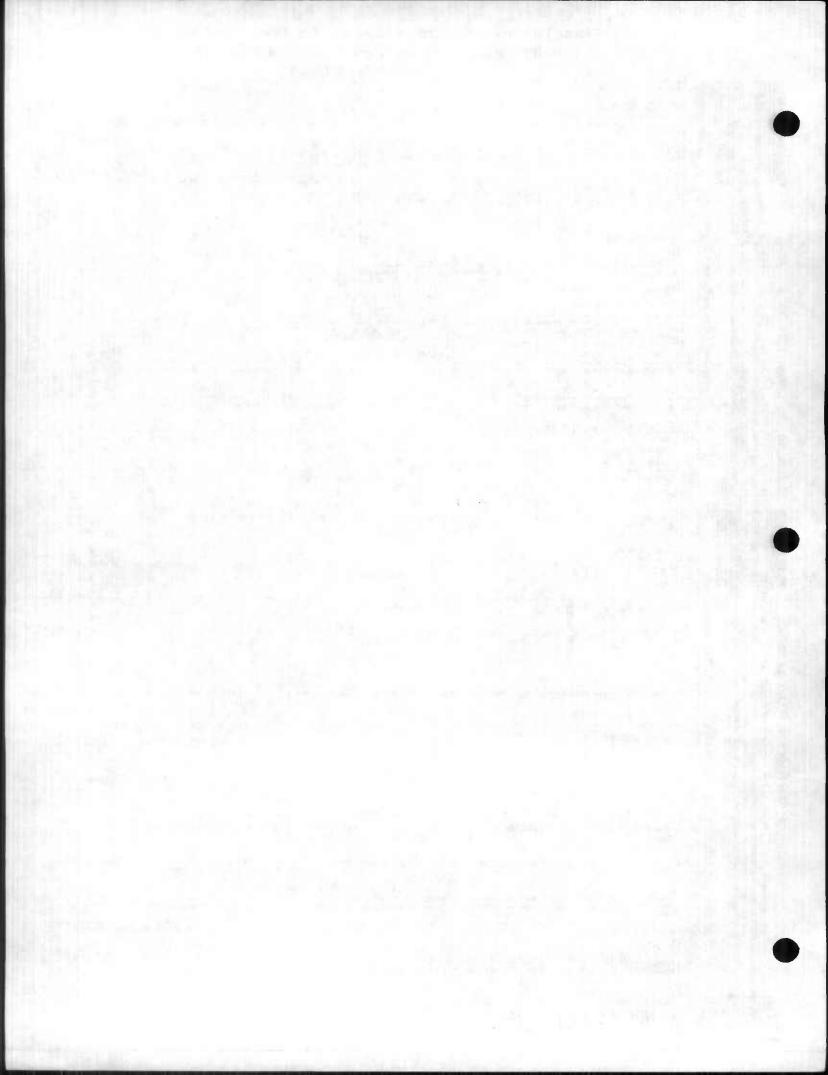
		Certificate of	Death	Reg.	No.	
1. Decedent's Name (First, Middle, Li	ast)			2. Date of Death Month	Dev Y	3. Tima of Death
cian MARGARE	T MARIE	JOHNS	SON	November		000 11.47 A
iner 4a Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or Lo		4c. County of	Death
	ORIAL HOSPI		BALTI			NIA
2.0 15 00118	Sex 7. Age (In yrs. lest to 1	birthdey) If Under 1 Year Months Days		8. Date of Birth (Month, Dey, Ye	ar) 9	Birthplace (State or Foreig Country)
Usuel Residence of Decedent	07	110.		APRIL 16,	1916	MARYLAND
10a. State 10b. County	10c. City, To	wn or Location		1 1/2		10d. fnside City Limit
\$ MARYLAND À	1/A	BAIT	-I HORE	CITY		1 Yes 2□N
MARYLAND A 10e. Street and Number		10f. Zip Code	MORE	/ 10g.	Citizen of Wha	at Country?
	-NNON DRIVE		2121	3	45	A,
11. Merited Status 1 Never Married 2 Merried	12. Was Decedent Ever in U,S. Armed Forces?	13. Wes Decedent of If Yes, specify Cut	Hispanic Origin? (Sp ben, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indien, White, etc.
	1 Yes 2 No	1□ Yes 2⊠No			Specify:	ningl
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(Specify only highest gr Elementary/Secondary (0-12)		Sa. Decedent's Usual Occu (Give kind of work done life, DO NOT use retire	during most of work	ing	. Kind of Busin	ness/industry
Elementary/Secondary (0-12)	College (1-4or 5+)	. 1	MAKER	/	SWN	HOME
17. Father's Name (First, Middle, Last	()	1101112	1	e (First, Middle, Mail		
MORRIS	(STHO	EMM	4	7	TOHNSON
19a. Informant'a Name/Relationship	(Type, Print) 19	9b. Mailing Addrass (Stree				
BESSIE WAR	D (NEICE) :	2216 WES	T SARA	TOGA ST	BAL	TTHORE, HD 212
20a. Mathod of Disposition	20b Place	of Disposition (Nema of tery, cramatory or other ple		Dete 20d	Location - Cit	ity or Town, State
	nplications that caused the death. Do yone cause on each line.	o not enter the mode of dy	ing, such as cardiac	or respiratory a rest	DALIO,	Approximata Interval Between Onset end Death
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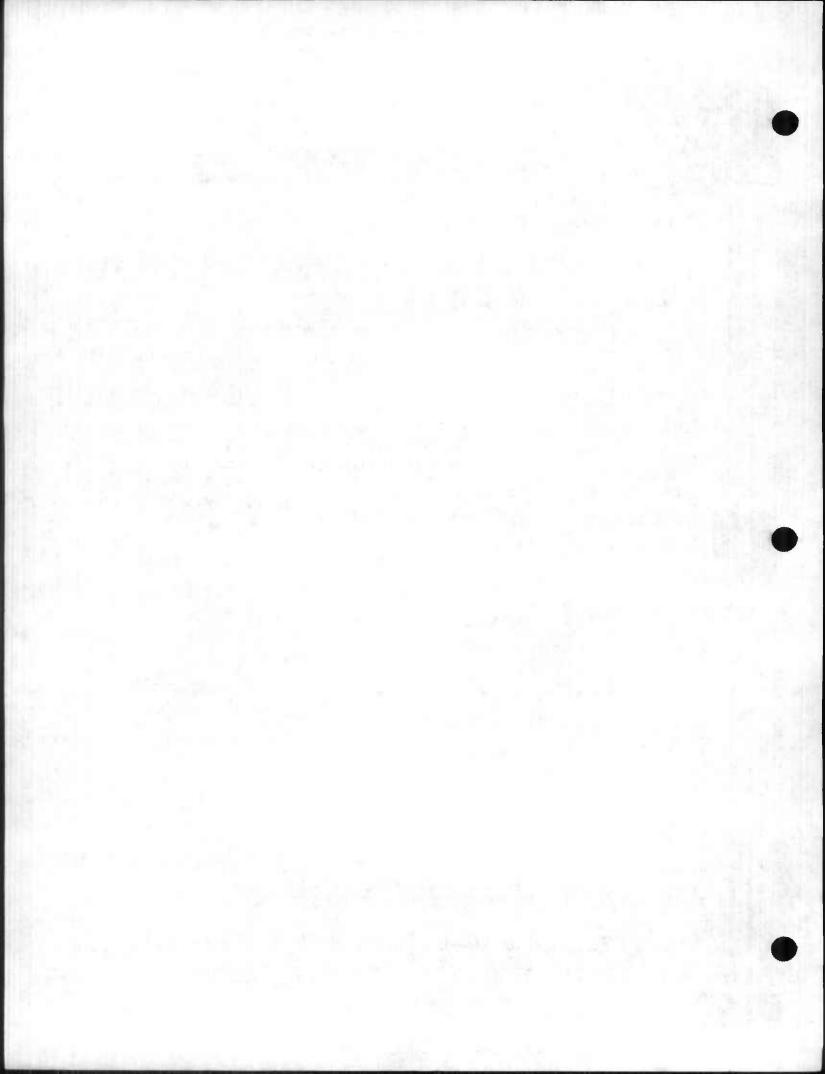
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			Certificate of	Death	Reg.	No.		
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Examiner	4a Facility Nama (II not institution, give Saint Joseph M			4b. City, Town, or Loc	ation of Death	4c. County of Dee	ath timore	
Funeral Director	5. Social Security Number 6. Security Number 11	7. Aga (In yrs. le	Yrs. If Undar 1 Yaar Months Days	Hours Min.	8. Data of Birth (Month, Day, Yell NOV 24, 1		inthplaca (Stata or Foraign Sountry) ARY LAND	
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at, or hams 23s Examiner must by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedent Evar in U,S Armed Forcas? 1 ☐ Yas 2 ☐ No WW If Yas, Giva Yaar or Datas:	S. 13. Was Decedant of H If Yas, specify Cub	Hispanic Origin? (Spean, Maxicen, Puarto F	city Yas or No- lican, atc.)			
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Departm Departm Importar any Inju	21. Signature of Funaral Sarvice Licens		22. Nama and Addra	ass of Facility	ANS FUN			
Physician /Medical Examiner	Immediate Cause (Final disease or condition rasulting in death)	SEPSIS DUE	. Do not antar tha moda of dyi	ng, such as cardiac o	raspiratory arrast,	vicce	Approximata Interval Batween Onset and Death 4 DAYS	
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b ga A	ACUTE GASTROINT	ESTINAL BLEED!	ING FOR 3 DAYS		1 Yee	20 No 3	Probably 4 🗌 Unknown	
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£ 5 8	27. Magnar of Death 1 Natural 5 Panding 2 Accident invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of 28c. Inju		28d. Dascribe how i		, and the same of	
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral Medical Certification:	3 Suicida 6 Could not be datermined	28a. Place of Injury - At hor building, atc. (Specify,	me, farm, street, factory, office	2	81. Location (Stree City or Town, S		Rural Routa Number,	
To the Hospital within 24 hours and the Funeral completely filled		rsician: To tha best of my know iner: On the basis of examinati and mannar stated.	on and/or investigation, in my	opinion, death occurre	ed at the time, date	and place, end de	ue to the cause(s)	
with To the Com	29b. Signatura and titla of certifiar Maturida	of D. de Le	on, M.D. D 19	sa number 508		Data signed (Mon	onth, Day, Year)	
20	30. Nama and addrass of person who o	omplated ceusa of death (Itam ELEON, M.D.,	23a) (Type, Print) 76 Ø 1 OSLER	DRIVE T	OWSON,	MARYLAN	ND 21204	
State	31. Data filed (Month, Day, Year)	32. Registrar's Signat	& Sparks	- N-11				

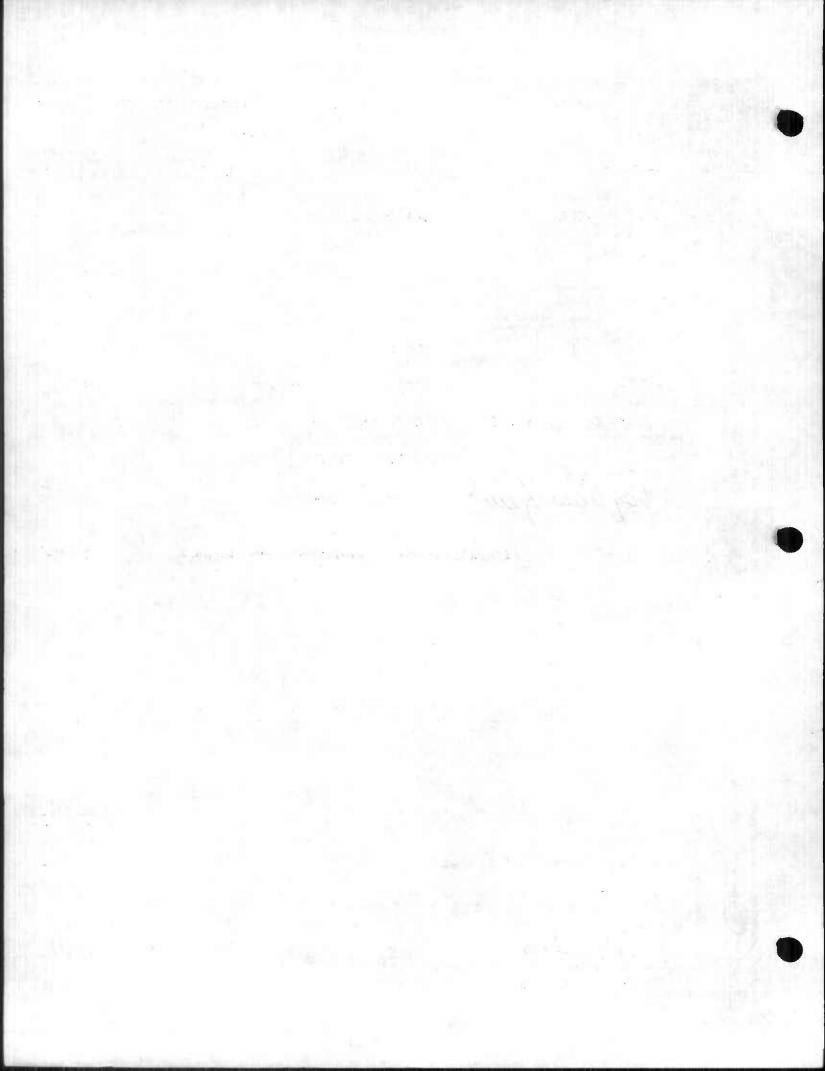


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State of Maryland / Department of Health and	d Mental Hygiene

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ian	н		AARON	KINE					Month NOVEMBER	Day 16,		oo 6	:07P			
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	13	HILLSIDE	HOUSE							CLARK	SVIL	LE	HOW	ARD		
		Social Security Num	11 5 1	Sex 12XM 2□		(In yrs.	last birthday) If Unde Months	er 1 Year Days		24 Hrs. Min.	8. Dete of Birth (Month, Dey,			Birthplaca Country)	(State or F
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	-	a. Stete 1	0b. County			10c. Cit	ty, Town or L	ocation							10d. li	nside City
by Funeral Director		MD	HOWARI	CLARKSVILLE					E				1 □ Yes 2			
	100	10e. Street and Number					10f. Zip Code					10g. Citizen of What Country?				
		5502 HARRIS FARM LANE					21029					U.S.A.				
	11.				12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent If Yes, specify C			edent of I	of Hispanic Origin? (Specify Yes or No- cuban, Mexican, Puerto Rican, etc.)						ndian,	
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		3 ₩ Widowed 4	Divorced	If Yes, Give Year or Dates:				10 103	2/2 140	Specify.			Specify: WHITE			E
Be Completed		(Specify	5. Decedent's Ed only highest gra				(Give	a. Decedent's Usual Occupation (Give kind of work done during most of wor			of work		16b. Kind of Business/Industry			у
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ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Year Month 2:45 pm Charles J. Lenert 18 2000 11 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 418 N. Milton Ave. n/a Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Data of Birth (Month, Day, Year) 6-10-1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Hours Maryland 213-28-7663 70 Usual Rasidenca of Decedant 10a. Stata 10b. Count 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 418 N. Milton Ave. 21224 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1951–55 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Years 4 Years Electronics Instructor 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Charles J. Lenert Anna Killian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 418 N. Milton Ave. Baltimore, MD 21224 Sarah Lenert (Wife) 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-22 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. Rosedale, Maryland 22. Nama and Address of Facility Moran-Ashton Funeral Home, Inc. 21224 3000 E. Baltimore St. Baltimore, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, List only one cause on each line. Approximate Intarval Batween Onset and Death a Squamow Cell Lung Concer - Let love lobe Immediata Ceusa (Final 2 months disaasa or condition rasulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Diseese or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 2 Yea 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa ot death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

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Hygiene. other than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at

Pages 1 and 2 should be filed nent of Health and Mental Hyginner: If Itam 27 is marked other

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physician s the burla # signed by the a

Charles Lenert

Be

To the Hospital or with 0.24 hours at To the Funeral D completely filled

State Registrar

Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. Chronic Obstructive Pulmonan Disease Right apper lose lung cancer (recented) Squamow Cell Cancer of the tongue 25. Was case ratarred to medical examinar?
1 ☐ Yas 2 ☐ No 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Pasidenca 6 Othar (Specify) 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 | Yes 2 | No 2 Accident 6 Could not be determined 3 ☐ Suicida 28t. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide edical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end dua to tha causa(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, deta end place, and dua to the cause(s) and manner stated. 29a. Certifian

29b. Signatura and title of certifier W. W.Q.M.D.

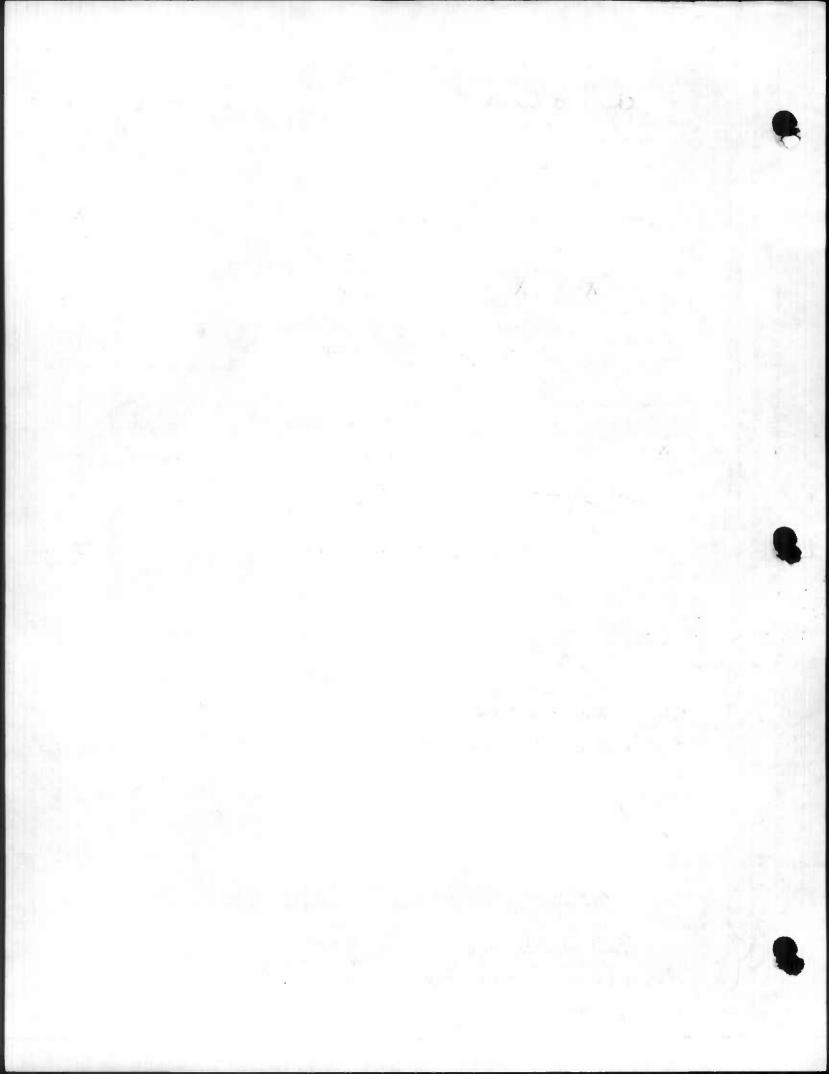
29c. License number D41476 29d. Data signed (Month, Day, Year) 11.19.2000

30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print) 6565 N. Chanes St. #416 Brulling

Reymond W. Wilson M.D 21204 Md.

31. Data filed (Month, Day, Year) 32. Registrar's Signature

NOV 2 2 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Patricia Ann Locke November 20, 2000 4:10 P.M. 4b. City, Town, or Location of Death 4e Fscility Name (If not institution, give street end number) 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 8. Dete of Birth (Month, Day, Year) Tan. 21, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 10 M 20 F Deys Hours Yrs. 78 483-20-3521 Iowa Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12103 Tullamore Court, Unit 102 21093 United States 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus I XYes 2 No If Yes, Give Year or Detes: WW II 1 ☐ Never Merried 2 Nerried 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent'e Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Teacher Education 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Elbert Woodworth Erma Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) 12103 Tullamore Ct. Unit 102, Timonium, MD 21093 Frank E. Locke (Husband) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Nov. 22, 1 ☐ Burial 2 Cremetion 3 ☐ Removel from Stete Bayview Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Baltimore, Maryland 22. Neme end Address of Fecility Chisholm Funeral Services of Dulaney Valley, P.A. 200 East Padonia Road, Timonium, MD Approximete Intervel Between Onset end Death Port1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Immediete Cause (Finel disease or condition resulting in deeth) Subarachnord 2 months Due to (or es a consequence ot) Sequentially list conditions, if eny, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence ot): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospite Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 XNo

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

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Maryland 21215-0020

Baltimore,

P.O. Box 68760,

of Vital Records,

Division

Pages 1 and 2 should be ment of Heelth and Mental

partment of Health portant: If Item 27

Physician/Medical Examiner p Be Completed

27. Menner of Death

1 Neturel 2 Accident

3 Suicide

29a. Cartifier

4 Homicide

29b. Signature and titli

or Attending Physician: Medical Certification: To after death. the completaly filled in by withfin 24 hours a To the Hospital

State Registrar

DHMH 16 Rsv 6/95

31. Dete filed (Month, Day, Year)

mo

Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number 1) 25205

28c. Injury et Work?

1 Yes 2 No

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Dey, Year) November 21, 2000

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

30. Name and address of person who complained cause of death (Item 23a) (Type, Print)

W. A. Rilley

G701

M N. Charles St. Balto. Md 21204

32. Registrer's Signeture

5 Pending investigation

6 Could not be determined

21,2000

4081S

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #12 & 18 G791 01-03-01 SS 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20, 2000 mq00:8 Nov. Norman /Medical 4a Facility Name (II not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 24 Hrs. 8. Da Hours Min. M Drive 2861 Bookert If Under 1 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months XXM 20 F 218-12-1447 80 Director 02-24-20 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show solical Examiner must be notified at Director MD 1 Yes 2 □ No NA Baltimore 10e Street and Number 10f Zin Code 10g. Citizen of What Country? USA 21225 2861 Booker T.Drive Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Yes 20 No 1 Yes 2 No Specify py 3 ₩idowed 4 Divorced Year or Dates: Black Completed I've Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Terminal Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift operator Dundalk Marine 7th Grade Pages 1 and 2 should be filed tent of Health and Mental Hygi mt. If Nem 27 Is marked other 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Emma Wicks Lomax Hodge George Lomax 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21620 nt of Health a : If hem 27 is or other tra 8520 Caulk Field Road Chestertown, MD. Cassie Lively 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State MD. 1X Burial 2 ☐ Cremation 3 ☐ Removal from Stafe Department of Important: If any Injury or Dage. 11-25-2000 Chesterstown, Haddaway Chapel 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Fecility Baltimore, Maryland 21202 Worre WM.C.March FH 1101 E. North Avenue 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) alor Physician/Medical Due to (or as a consequence of): S OSO signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed page 2 s certificats has 1 Yes 2 ₽No 1 □ Yes 2 □ No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Mesidenca 6 Other (Specify) 20No OL 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menney of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Matural 5 ☐ Pending n 24 hours after death.

The Funeral Director: After pletely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier edical 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 g.

State Registrar 31. Date filed (Month, Dey, Year)
NOV 2 2 2000

29b. Signature and fitle of certified

M.D. 32, Registrar S Signature 29d. Date signed (Month, Dey, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Typa, Print) KARHINENI

muen H.

S-Kall

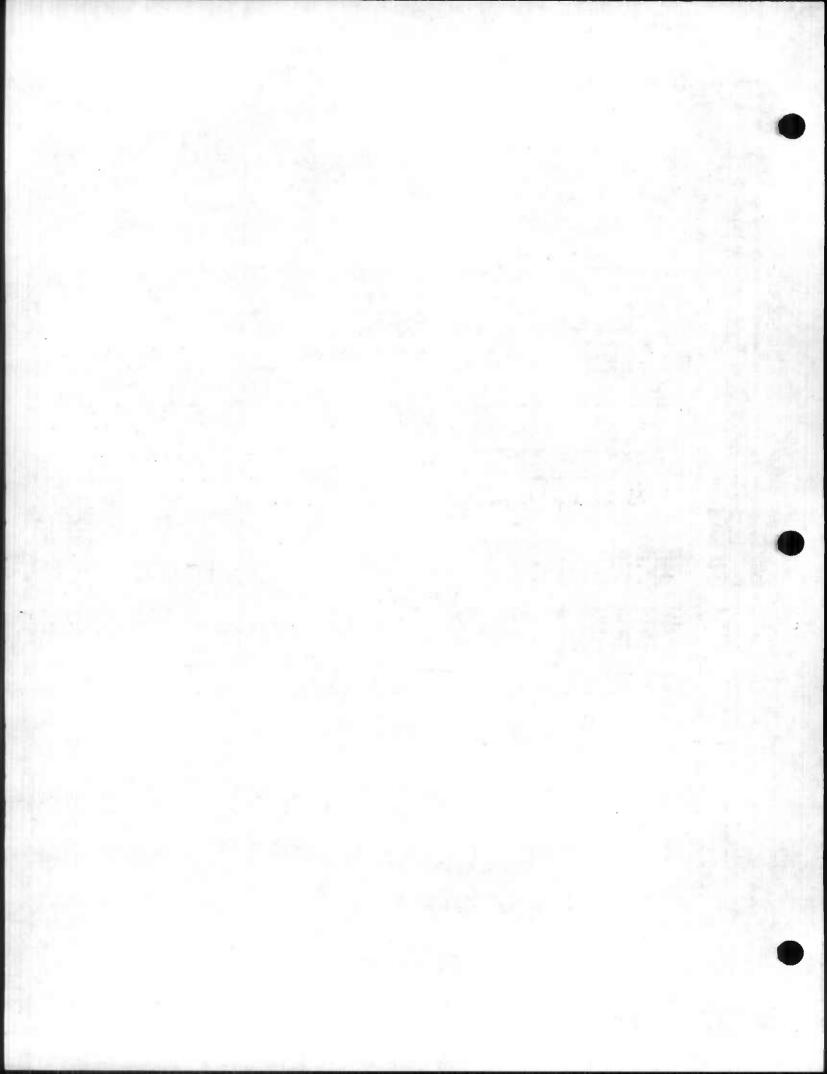
HOUDANNAPOLIS RD, BALTIMOLE, MD 21227

altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

29c. License number

D26307



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nema (First, Middla, Last) Day L00 V13 dwin 20 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death St. Agnes Hospital 900 Caton Avenue Baltonore, MD Hundar 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 20, 1922 5. Sociel Security Number tf Under 1 Year Sex 1 XM 2 ☐ F 7. Age (In yrs. lest birthdey) Birthpiece (Stata or Foreign Country) Months Days Yrs. 220-07-4257 Maryland Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☑ No Baltimore Halethorpe 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1225 Oakland Terrace Road 21227 USA 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 X Yes 2 No 1942 If Yes, Give Yeer or Detes: 1945 1 Nevar Merried 2 Married 1 Yas 2 XNo Specify: Specity: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Self-employed Gas service station 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Martie B. Loovis Ona Cawood 19e. Informent's Name/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1225 Oakland Terrace Road, Halethorpe, Maryland21227 Boa of Disposition (Name of Date 20c. Location - City or Town, State Virginia Staub Loovis-wife 20b. Pteca of Disposition (Neme of cemetery, cremetory or other plece) 20e Method of Disposition 1 🕅 Buriel 2 □ Cremation 3 □ Removal from Stata 11/24/2000 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Witzke Funeral Home 21. Signeture of Funeral Service Ligani 5555 Twin Knolls Road, Columbia, Maryland 21045 23a. Part1. Entar the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feiture. List only one cause on each line. Approximata Intervel Between Onset end Death tmmedlete Ceuse (Finel disaasa or condition resulting in deeth) Due to (or es a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or trijury that initiated events resulting in death) Last Due to (or es e consequenca of) Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy 1 Yas 200 No 1 Yas 2000 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No npatiant 2□ ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Daturet 5 Pending invastigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) end menner stated. 29e. Certifier

Box 68760, or Attending after death

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

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or Herrie

Baltimore, Maryland 21215-0020

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Department of Health a Important: If Item 27 is any Injury or other trau

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/Medical Examiner

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Physician/Medical

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within 24 hours To the Funeral Completely filled

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Dey, Year)

29b. Signature and fitte of certifie

29d. Date signed (Month, Day, Year)

30. Name and address (Types Print) JURMUE

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32. Registrer's Signeture

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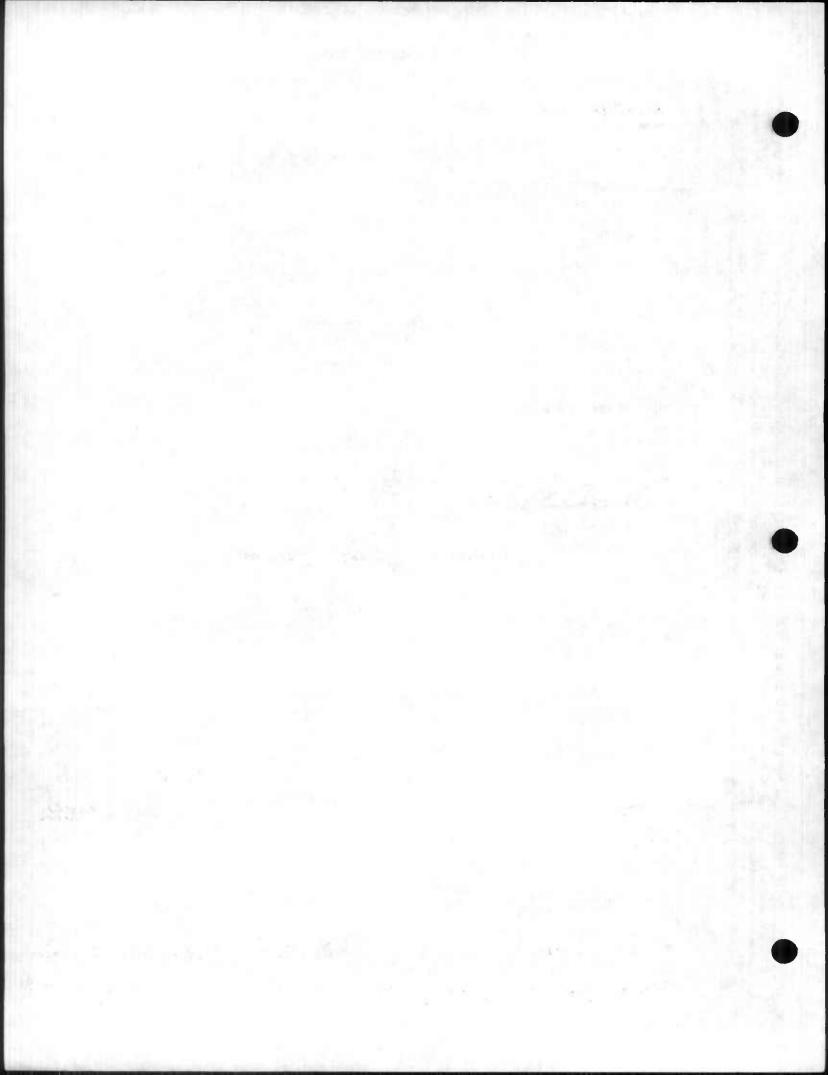
Agatha

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Data of Death 3 Time of Death **Physician** AGATHA MAKOWSKI November 20. 2000 12:50 AM /Medical 4a Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City
| Frunder 1 Year | Frunder 24 Hrs. | 8. Deta
| Months | Days | Hours | Min. | Months | Min. | Months | Min. | Months | Months | Min. | Months Heartlands Assisted Living Howard 8. Deta of Birth (Month, Day, Year) April 1, 1912 Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□ M 23 F Yre. 212-28-6922 88 Md. Director Usual Rasidence of Decedant r 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Howard Ellicott City 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? r than "natural", or itema 23a or the Medical Examiner must be r 3004 North Ridge Rd. H-102 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frema 23a and injury or other traumatic avent, the Medical Extrans. 21043 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispenic Origin? (Specify Yas or No If Yas, specify Cuban, Maxicen, Puerto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Detas: 1 Never Married 2 Married 1 Yas 2 No Specify: Specify. by 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Cottege (1-4or 5+) 8 Laborer Factory 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Intlekofer Louis Ludwig Elsa Elizabeth 19a. tnformant's Name/Retationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 15549 Carroll Rd. Mrs. Paula Tilley/great niece Monkton, Md. 21111 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramovel from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Hilltop Service Corp. 11/21/00 Towson, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tntarval Batwaan **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) CONGESTIVE HEART PAILURE 4 EARS Examiner Dua to (or as a consequance of) Examine siclan and burial-transit Sequentially tist conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): physician s the burial Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Wara autopsy findings available prior to complation of ceusa of daath? Be Completed 24a. Was an autopsy performed' 1 Yas 2 No Vital 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) ASS 57 7 1 Yas 2 No of this 27. Mannar of Death 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of After Division Hospital or Attending 5 Pending invastigation 1 ANatural ster death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide within 24 hours aft To the Funeral Di completely lilled In 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier (Check only one) and mannar stated. 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 051660 -MD NOVEMBER 20, 2000 30. Nama and addrass of person who complated causa of death (ttam 23a) (Type, Print) 3460 ELLICOTT CTA DA HIOS ELLICATT CIPT MO 21043 JONATHAN FISH MO 31. Data filed (Month, Day, Year) 32. Ragistrer's Signatura Registrar NOV 2 2 2000 Oaks

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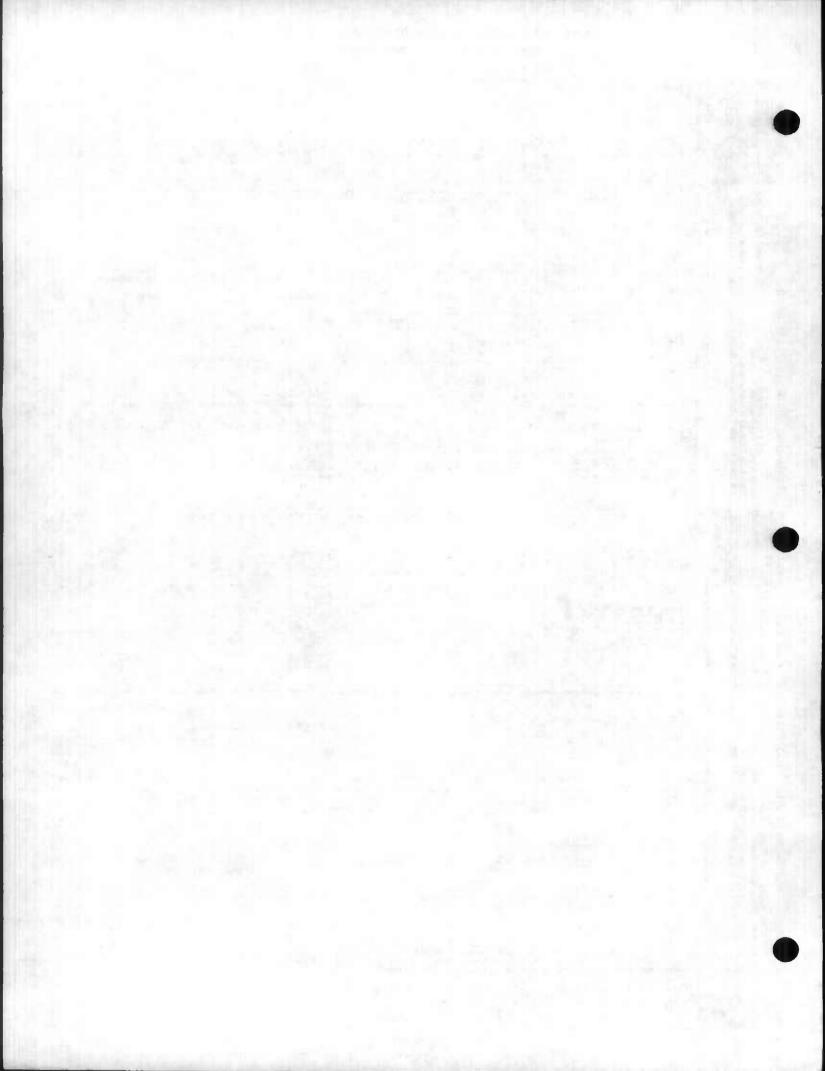


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State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 0 2 4

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-	es 2 No	ner? Hospitel: 1 Inpatien ses 2 No 28e. Dete of Injury sturel 5 Pending coident Investigation	her? Hospitel: 1 Inpatient 2 ER/Out ses 2 No	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DC or of Death sturel 5 Pending investigation licide 6 Could mixe be	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing or of Death sture! 5 Pending investigation uicide omicide 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work? 1 Yes 2 No 28e. Pleca of Injury - At home, term, street, fectory, office	ase referred to medical ner? Hospitel: Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resider	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other work? Injury M 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury Monk? Codent uicide omicide 28e. Pleca of Injury - At home, term, street, fectory, office 28e. Location (Street and Number City or Town. State) 28e. Pleca of Injury - At home, term, street, fectory, office 28f. Location (Street and Number City or Town. State)

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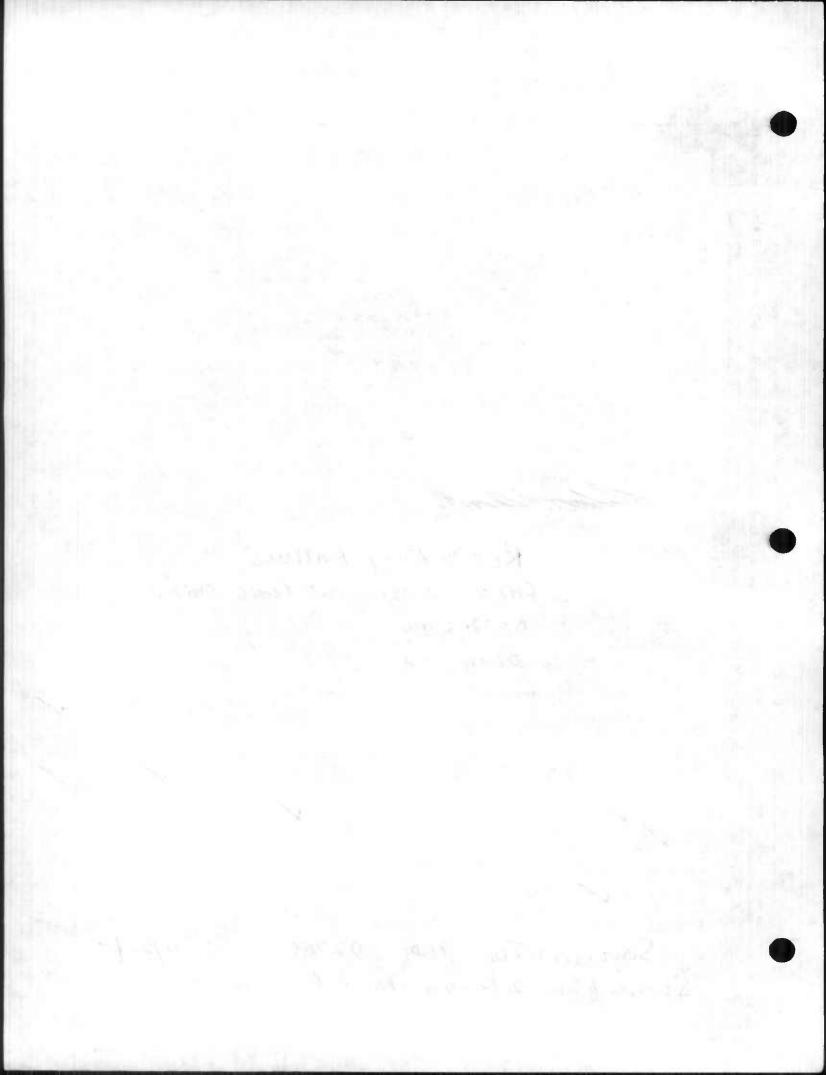
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State of Maryland / Dep

	3	.)	/ / 1	1	L
partment of Health and Mental Hygiene	UU	Ü	U	6.	4

			Certificat	te of	Death		R	leg. No.		
Decedent's Name (First, Middle,	Last)						2. Date of Dea		Vees	3. Tima of Dea
FRANCES CHRIST	INE MAJKA-	SULLTVAN					Month VOV. 22	, 2000	Year	12:30 a
Facility Name (If not institution,					4b. City, To		ation of Death		of Death	172.50 0
HERITAGE GERIA	TRIC CENTE	P			RAI	TIMO	0 F	RAIT	IMOR	F
		ge (In yrs. last birti	ndev) If Unde	r 1 Year						
5-05-4733	10 M 20XF		rs. Months	Days		Min.	6. Date of Birth (Month, Day Sept 1	0,1913	MARY	place (Stele or Fontry) LAND
. State 10b. County		10c. City, Town	or Location						1	10d. Inside City Li
110			. ==1/20=						111	XXYes 2
MD. N/	A	L BA	LTIMORE					0 011	100	
			101. 21	p Code				Og. Citizen of V	vnat Cou	ntry r
602 S. ANN STR	EET			123				U.S.A		
Marital Status	12. Was Deceden Armed Forces	t Ever in U,S.	13. Was Dece If Yes, spe	dent of cify Cut	Hispanic Ori pan, Mexicar	igin? (Spec n, Puerto R	cify Yes or No- tican, etc.)	14. Rac	a - Americk, White,	can Indian, etc.
1 Never Married 2 Marrie	d 1 ☐ Yes 2 ☐	χίνο	1□ Yes							
¾(XWidowed 4 □ Divorced	Year or Dates		10163	26,20,140	ороспу.			Specify	WHI	TE
15. Decedent's	Education	16a.	Decedent's Usu	al Occu	pation	at and assemble to		16b. Kind of Bu	usinass/In	dustry
(Specify only highest lementary/Secondary (0-12)	Collega (1-4or		(Give kind of wo life. DO NOT u	ise retire	ed)	. O WOLKIN	9			
8	OU1094 (1-40)		MESTIC					BALTO.	CITY	SCHOOLS
Father's Name (First, Middle, L.	ast)				18. Mothe	er's Name		Maiden Sumem		O DITO V. L.
STANISLAUS MA	LINDWONT				MADI	/ / / / / / /	A WROBL	EUCVT		
3 I AN I S LAUS MA a. Informant's Name/Relationshi		10h	Mailing Address	s (Stree				r, City or Town,	Stata 7ii	Code)
ANIEL MAJKA/ S Method of Disposition	UN		/ 48\(\tau\) Disposition (Ne		EEI, BA	LILMO	-	YLAND 2 20c. Location -		
1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	comoton	, crametory or	other ple	ece)		Date	20c. Location -	City or 1	own, State
4 ☐ Donation 5 ☐ Other (Spe	ecify)	ST. ST	ANISLAL	IS C	EMETER	RY 71,	125/00	BALTIMO	RE, M	ARYLAND
Signature of Funeral Service Li	censee		22. Name a			•				
1		- //	LILLY	& Z	EILER	INC.	FUNERA	L HOME ORE, MAR		0 01001
quentially list conditions, ny, laading to immediate ise. Entar Underlying use (Disease or injury Linitated evants ulting in death) Last	. DEP	Due to (or as a complete to (or a) com	onsequence of) onsequence of)	:	VE C	love	G DIS	EASE	1	
ttl. Other significant condition				cause g	iven in Part	1.	23b. Did t	obacco use co	ntribute 1	o the cause of de
							101	res 2□ No	3 □ Pro	bably 4 h
							24a. Was a perfor		av cc	era autopsy findin vailable prior to completion of cause death?
							1 1 Y	es 20 No	1	□Yes 2 No
Was casa referred to medical					26 Place	a of Death	(Check only or	nel		
examiner?	Hospital:	tient 2 ER/Out	patient 3 D	04 0	ther .			ence 6 Oth	or /Snan	ifich
Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of In (Month, D			28c. Inju		2		ow injury occur		,,,,
3 Suicide 6 Could no datarmin	28a. Place of li building, e	njury - At home, far atc. (Specify)	m, street, factor	ry, office		2	8f. Location (S City or Tow	itreet end Numb n, Stete)	er or Rur	ral Route Number,
Certifier (Check only one) 1 Certifying 2 Medicat E	Physician: To the bes xaminer: On the basis and manner s	of axamination and	death occurred for invastigation	at the t	ima, date ar opinion, das	nd place, ar ath occurre	nd dua to the d d at tha tima, d	ause(s) and ma data and place,	anner as a	stated. to the cause(s)
. Signature and title of certifiar	and manner	Nation.	29	c. Licen	se number	-		29d. Date signe	d (Month.	Dev. Year)
P			45) 2	7.00			1. /-	_ /_	() () () () () ()
Savindo	16/ Len	M-D	. 1	12	1188			11/2.	2/00	7
Nama and address of person w	ho complated cause of	death (Item 23a) (Type, Print)	0				/		
Disholy 1/4.	W. 2 M	anli 21-	Place	Ba	Hilm	ere 1	41) -	21222	_	
Date filed (Month, Dey, Year)	32. Regis	trar's Signature	,	1						
Nama	Saving & and address of person w	Scuring a 167 lelk and address of person who complated cause of indu Krully 2 M	Scuring a 16 Tillia MD and address of person who complated cause of death (Item 23a) (To Indu 16 Mullia 2 Manual Colored Color	Scuring a 16 There M.D. 13 and address of person who complated cause of death (Item 23a) (Type, Print) in the 18 Market Place	Savinge 167 Lega M.D. 1) 2 and address of person who complated cause of death (Item 23a) (Type, Print) and Whelle 2 Market Place Ba	Schride 10 There M.D. 1) 27188 and address of person who complated cause of death (Item 23a) (Type, Print) Balting	Savinge 167 Lella M.D. 1) 27188 and address of person who complated cause of death (Item 23a) (Type, Print) and 16 Mella 2 Marle 2 Place Balliner 1	Schride 167 Lella M.D. D. 27188 and address of person who complated cause of death (Item 23a) (Type, Print) and Whele 2 Marlet Place Baltimer M.D.	Schride 167 Lelia M.D. D. 27188 11/2. and address of person who complated cause of death (Item 23a) (Type, Print) and Whele 2 Marlet Place Baltimer M.D. 21222	Schride 167 Lelk M.D. D27188 11/22/00 and address of person who complated cause of death (Item 23a) (Type, Print) and Whele 2 Marle 2- Place Baltimer MD 21222

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Pages 1, 2, 3 should

use as the burlaf-transit permit. retained by the hospital or attending physician. page 5 should be detached for once. Ħ notified hours after death. Page 6 may be e must funeral director, examiner the medical filled in by the ö the cremation, event, executed within TO0 burial, traumatic and ung physician a certificate be other the attending p 6 DR ATTENDING PHYSICIAN: The law requires that the death certificate has been signed by the State Dept. of Health and any shows : 23 0 marked, this (After .00 DIRECTOR: A hours after d item FUNERAL D within 72 h HOSPITAL. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. MCLEON - DELITAH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH YEAR Bos MCLEOD-MATTHEWS BABY 3:45 2000 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign SEPT. 10 1 M 2 F INFANT MARI None 9a. FACILITY NAME (If not institution, give stre 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF GEATH PRINCE GEORGES HOSPITAL CTR CHEVERLY PRINCE GEORGES DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 18c CITY TOWN OR LOCATION 10d. INSIDE CITY PRINCE GEORGES FORT WASHINGTON MARYAND 1 X YES 2 NO 10a. STREET AND NUMBER FUNERAL 101. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 1813 THORNTON DRIVE 20744 U.S.A 12. WAS OECEOENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ₺ NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS OECENOENT OF NISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married ВҰ 3 Widowed 4 Divorced BLACK COMPLETED 15. OECEOENT'S EOUCATION 16a. OECEOENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INOUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) INFANT nare INFANT None 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) DAMON LEROY MATTHEWS CAPRICE MCLEDO 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ERICA CAPRICE MGLEDO 1813 THORNTON DRIVE FT. WASH, MO 20744 20a. METHOD OF DISPOSITION or complications that caused the death. Do not enter Approximata ock, or heert fellure. Liet only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onaet and Death disease or condition neue Overnaturity
DUE TO (OR AS A COUSEOUENCE OF): resulting in death) chorioamnionif CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF) if any, lesding to immediate cause. Enter UNDERLYING rupture of membranes emature CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF that initiated events reaulting in deeth) LAST incompetent cervix PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AMIL ARLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 TYES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🛛 UNCERTAIN 🗆 PHYSICIAN: 28. PLACE OF OEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER:
4 □ Nursing Nome 5 □ Residence 8 □ Other (Specify) 1 YES 2 NO patient 2 - ER/Outpatient 3 - DOA 27. MANNER OF CEATN 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 28b. TIME OF 1 Natural 2 Accident 5 Pending BY Investigation

28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be determined

CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner as stated.

MECICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. DATE SIGNEO (Month, Day, Year)

CONSTRUCTION OF CERTIFIER	Meter mo	29c, LICENSE NUMBER D40 3 77	29d

30. THE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)
JEQUICE HC E. AKhter M.D.

MD 32. REGISTRAR'S SIGNATURE

repevas

Prince George's Hospital Center Cheverly, my oaks

NOV 2 2 2000

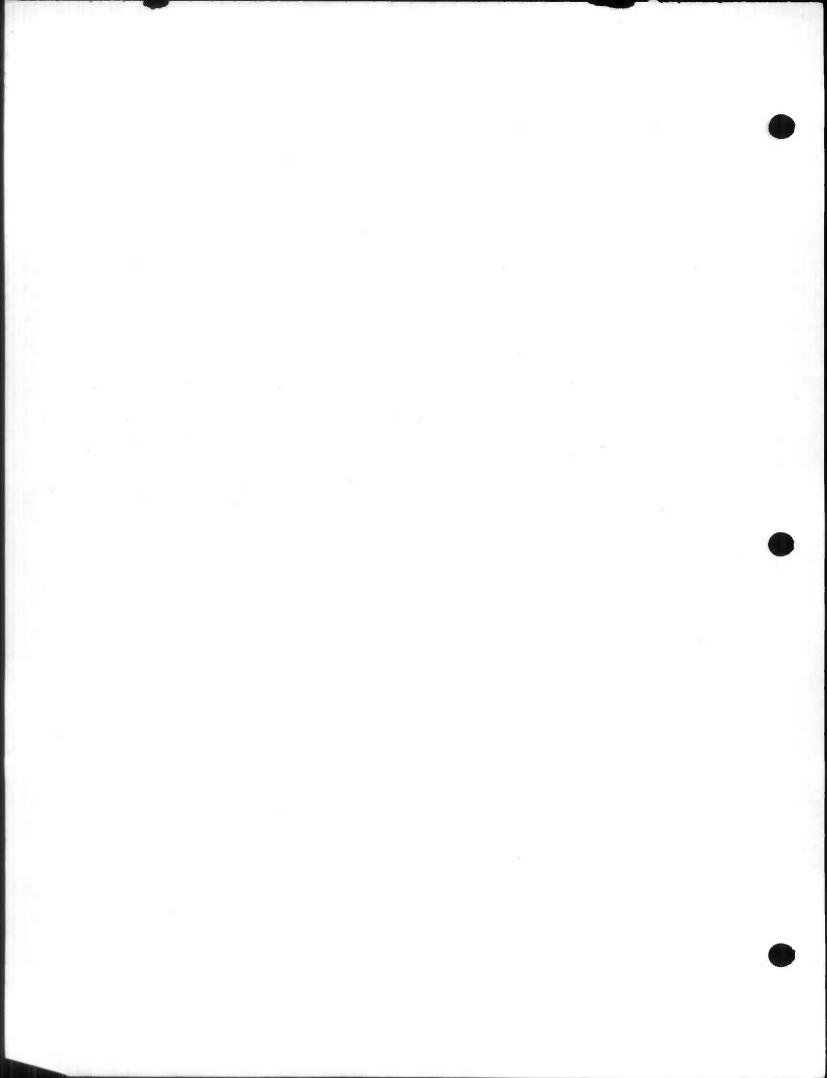
COMPLETED

BE

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29a, CERTIFIER

9-10-00

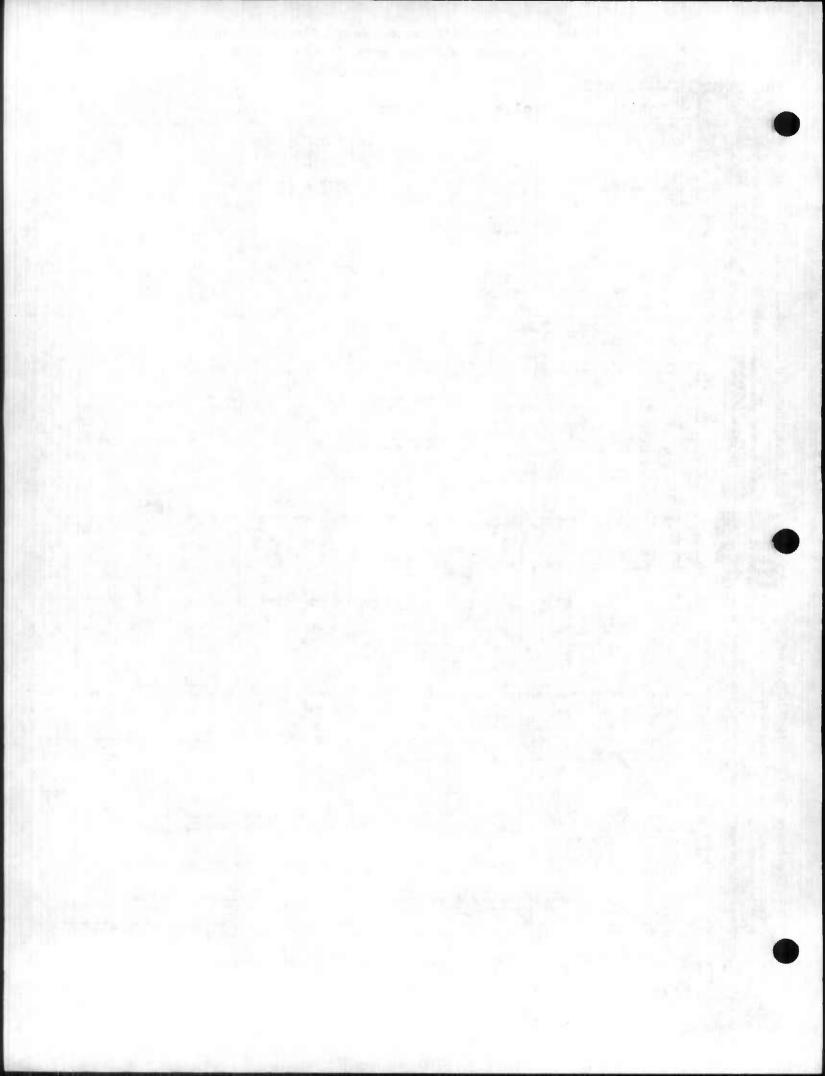


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			of Maryland		ertificate					leg. No.		
ician	1. Decedent'a Name (First, Middl								2. Date of Dee	th Dey	Year	3. Time of Death
dical	Annie	Evely		Me	ara				Novem	ber 19,	2000	4:30
iner	4a Facility Name (II not institution	The state of the s							cation of Deeth	4c. County		
	Ridgeway Manor 5. Sociel Security Number	Nursing 6. Sex	Home 7. Age (In yrs. las	et hirthd	If Under	1 Year	Caton			Balti		
	219-10-8136	1□ M 208F	86	Yrs	Months	Deys	Hours	Min.	8. Dete of Birth (Month Day May 2/	1914	Geo	plece (State or Fore nto) rgia
	Usual Residence of Decedent											
	10a. Stete 10b. County		10c. City,								1	10d. Inaide City Lim
octo		imore	Ca	tons	sville							1 🗆 Yes 2 🔀
Dir	10e. Street and Number 653 Coleraine R	D			10f. Zip (229			10g. Citizen of V USA		ntry?
Funeral Directo	11. Meritel Stetus		cedent Ever in U,S.	1	3 Was Decede			nin? (Sne	ecity Yes or No-			can Indien,
를	1 Never Merried 2 Merr	Armed F	orces?					, Puerto	ecity Yes or No- Rican, etc.)	Bled	ck, White,	
Dy	3 Widowed 4 □ Divorced	If Yes, G Yeer or	aive		1□Yes 2	X No	Specify:			Specify	/:	White
sted	15. Deceden (Specify only higher	's Education	1)	16a. De	cedent's Uauel ive kind of work a. DO NOT use	Occup done	ation	ol worki	ina	16b. Kind of B	usiness/în	dustry
nple	Elementery/Secondary (0-12)		(1-4or 5+)				d)			Over	n Hon	n 0
Be Completed by	1.2 17. Father's Name (First, Middle,	(ast)		1	Homemak	e1	18 Motho	r's Name	(First, Middle,			
o Be	Lewis Lawler	Ladi)							ckerson		,	
To	19a. Informent'a Neme/Reletions	hip (Type, Pnint)		19b. M	eiling Address	(Street	and Numbe	er or Rura	al Route Numbe	r, City or Town.	State, Zit	o Code)
	Ronald K. Meara	Son							more, M			
	20a. Method of Disposition			ca of Di	sposition (Nameremetory or other	e ol	Jan Pillon		Dete	20c. Location -	City or To	own, Stete
	1 ■ Buriel 2 □ Cremetion 4 □ Donation 5 □ Other (S		n State		cans Ce			1:	1/27 I	Reister	stown	n, MD
	21. Signature of Funerel Service	Licensee							wab Fune		_	
	the de			1		_			Baltimo			
	23a. Rant1. Enter the disease, or shock or heert allure. List	complications that	caused the deeth.									Approximete Intervel Between
		V		A 7	0 <	_	7	1.				Onset end Deat
	Immediete Cause (Finel disease or condition resulting in deeth)	a	Y G CON	2	al -	71	Jare	TR	m		7	mmedi
Pr	Toolston,		Due to (or e	es a con	sequenca ot):						1	
Examine		b	Due to fee		annuana afti						1	
Exa	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or a	12 6 CON	sequenca of):							
dical	Cause (Disease or injury that initiated events resulting in death) Lest	С	Due to (or e	a a con:	sequence of):							
Med	resulting in death) Lest										1	
lan		d							0.0			
Physician/Me	Pert ii. Other eignificant condition	ns contributing to	death but not result	ing in th	e underlying ca	use giv	ven in Pert I		23b. Did t	obacco uae co	ntribute t	o the cause of de
									101	Yes 200 No	3 Pro	bably 4 Unk
d by									24a Was	en autopsy	24b. W	/ere eutopsy findir
Completed	No English to the State of the									med?	av	reileble prior to empletion of cause
dmo										(a 17/1)		death?
ပို	25. Was case referred to medica						26 61-	at Da = "	1 Y		11	□ Yes No
0	examiner?	Hospitel:	Inpatient 2 E	R/Outna	tient 3 DO	A Oth	200		n (Check only o		ar (Speci	ifv)
-	27. Menner of Death	28a. Dete		8b. Tim	e of 28	Bc. Injut			28d. Describe h			-7/
Certification:	1 Neturel 5 Pendin	ation	, Doy rour)	irijul	м		Yes 2	No				
TITIC	3 Suicide 6 Could determined	ined 288. Plec	ce of Injury - At hom ding, etc. (Specify)	ne, farm,	street, factory,	office			28f. Location (S City or Tow		ber or Run	ral Route Number,
edicai	(Check only 2 Medical	Examiner: On the I	e best of my knowl basis of examination									
Med	one) 29b. Signature and title of ceglifie		nner steted.		29e	Lipens	se number		11	29d. Date signe	d (Month	Day, Years
	× 21	011	17 4	0	1	17	336	5	1/16	11/	20	/
0	(alway	WIL	lule 1	1.01	n Bon	UL	0000			11/	20/	00
Y	30 Name and address of person	who completed cau	71C	tours	ea ().		1.	. 44	205, B	alkin	0.04	MA
ate	31. Date filed (Month; Day, Year)	W 1/11/C	Flegistrar's Signatu	CONT. OF	- N Cha	14	wely	6 11		1111	1	

DHMH 16 Rev 6/95

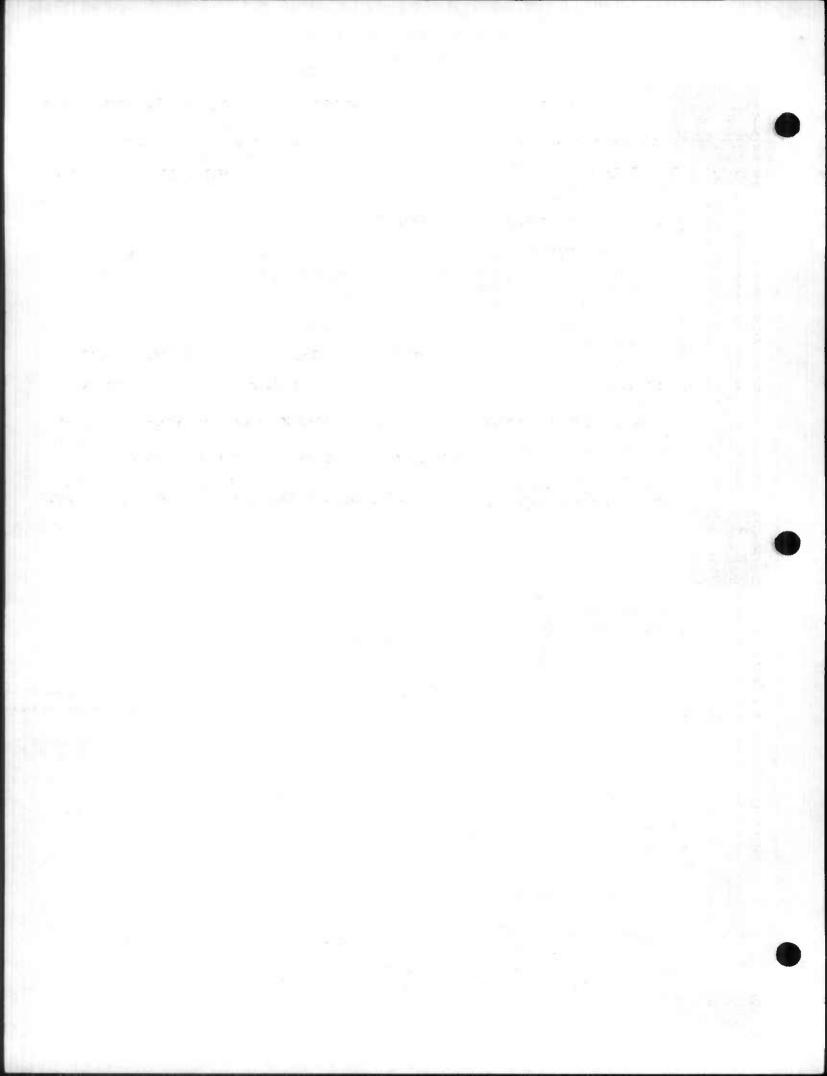
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				State of IV	iaiyiaiiu		ficate of		Mental Hyg	Reg. No.		
	Physic	ian	Decedent's Name (First, Middle, SHE				MEYER	C	2. Data of Dea	ERDAZO,	2/9P10	3. Time of Death 5:30 AM
	/Medi Examii	cal	4a. Facility Name (If not institution,		-)				Location of Death	4c. County		J.30 AM
	Exami	iei	CHESAPEAKE HO		,				HICUM		ARUN	IDEL
	Funeral Director		5. Social Sacurity Number 220–36–2939	8. Sex 7. A 1 □ M 2 🖾 F	ga (in yrs. ia:		If Undar 1 Yaar Months Days	If Undar 24 Hr Hours Mir		/, Year)	9. Birthpi Coun	laca (State or Foreign try) MD
	and w		Usual Residence of Dacedant 10e. Stete 10b. County		10c, City.	Town or Local	tion				11	0d. Inside City Limits
	Maryl faho	ō	A ASSESSION OF A ASSE	E ARUNDEL		ANNAPO						1 No 2 No
	3a or 28a	i Director	10e. Street and Number 129 SUMMER V		E		10f. Zip Code	2140		10g. Citizen of V		try?
020	i within 72 hours after death with the Maryland ilene. Than "natural", or Nems 23a or 28a-f ahow The Medical Examiner must be notified at	by Funeral	11. Maritai Status 1 Nevar Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces od 1 Yes 2 1 If Yas, Giva Yaar or Dates:	? I No	If Y	s Decedent of Pas, apecify Cub	dispanic Origin? (an, Mexican, Pua Specify:	Specify Yas or No- rto Rican, atc.)		e - Amarica k, White, e	
0200-61212	within 72 ho lene. than "natur the Medical	Completed	15. Decedant's (Specify only highest Elementary/Secondary (0-12)	grada completad) College (1-4or		(Giva kin life. DO		during most of wi d)	orking	16b. Kind of Bu		
0	高大寺市		17. Father'a Name (First, Middle, L	4 ast)		INTERI	OR DESI		ame (First, Middle,	INTERIO Maiden Sumam) I GIV
lan		To Be	SIGMUND			KATZ		DORO!			•	APIRO
, maryland	ith and ith and it is m traum		19a. Informant's Name/Relationsh MARC J. MEYER		D				Rural Route Numbe			
Baltimore,	permit. Peges 1 and Department of Healt Important: If Hem 2: any Injury or other: once.		20a. Method of Disposition 1 💆 Burial 2 □ Cramation 4 □ Donation 5 □ Other (Sp.		cen		on (Name of lory or other pie ON CEMET	*	Date 11/21/00	20c. Location -		
Dail	permit. Departr Importu any Inf		21. Signature of Funaral Service L	censee			Name and Address O REIST		SOL LEVIN			
			23a. Part1. Enter the disease, or o shock, or heart feilure. List o	omplications that cause nly one cause on each	d the death.	Do not enter t	he mode of dyl	ng, such as cerdi	ac or raspiratory an	rast,		Approximata Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disaasa or condition resulting in death) a. LEIOMYO SANCUMA OTIENUS Due to (or as a consequence of):									Onset and Death
ė.	D E	iner			240 10 (01	u 00.1100quu	1100 017.					
eo,	tificate be executed ig physician and as the burlal-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury	C	Due to (or a	as a conseque	nce of):				1	
		/Medical	that initiated events resulting in death) Last	d	Dua to (or a	s a consequar	nce of):					
DOX.	for for	Iciar	Part II. Other significant condition	a contributing to death i	hut not roould	ing in the code		see to Best t	ook Dida	-	- Anthony	Abo pouse of death
7.	that the ed by th deteche	by Physician/M	Tall II. Other significant condition	s contributing to death?	out not result	ing in the unde	enying cause gr	ren in Part I.	1 1	- d		the causs of death?
or vital necords,	aw requir is been s 2 should	Completed b							24a. Was a perfor	an autopsy med?	ava	ore autopsy findings allable prior to appletion of cause death?
	The ate h	Соп							1 🗆 Y	es 20 No	1 🗆]Yas 2□ No
21	Physician: The this certificate and director, page	Be	25. Was cese referred to medical examiner?	Hospital:			a□ DOA Ott	ar:	eath (Check only or			11
	등 등 등	ition: To	1 Yes 20 No 27. Manner of Death 1, Natural 5 Pending 2 Accident investigation	28a. Data of Inju	ury 2	R/Outpatient 8b. Tima of Injury	28c. Inju	4 Li Nursing	Homa 5 Reaid			HOUSE
DIVISION	교육	Certification:	3 Suicida 6 Could no 4 Homicide determin	Zea. Placa of in	jury - At hom tc. (Specify)	e, farm, atreet	, factory, office		28f. Location (S City or Tow		er or Rura	Route Number,
	27.85	edical C	29a. Certifier (Check only one) Certifying Certifying	Physician: To the best kaminer: On the basis of and mannar si	of examination	edge, deeth oo n and/or inves	ccurred et the ti tigation, in my c	me, date and place opinion, deeth occ	e, end due to the curred at the time, c	cause(s) end me dete and place, a	nner as st and due to	eted. the cause(s)
	of the second	W	29b, Signature and title of cartified	11. M			29c. Licens	se number	- 2	29d. Date signer		
}	N1		30. Name and address of person w	ho completed cause of	death (Item 2	3a) (Type, Pri	DC nt)	8//8		11/20	1/20	US
	010		700 BEST	SATE 1	20	MNN	MONUL	s Su	0 2	140/		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2. 2.		rar's Signatu	ra A	6					

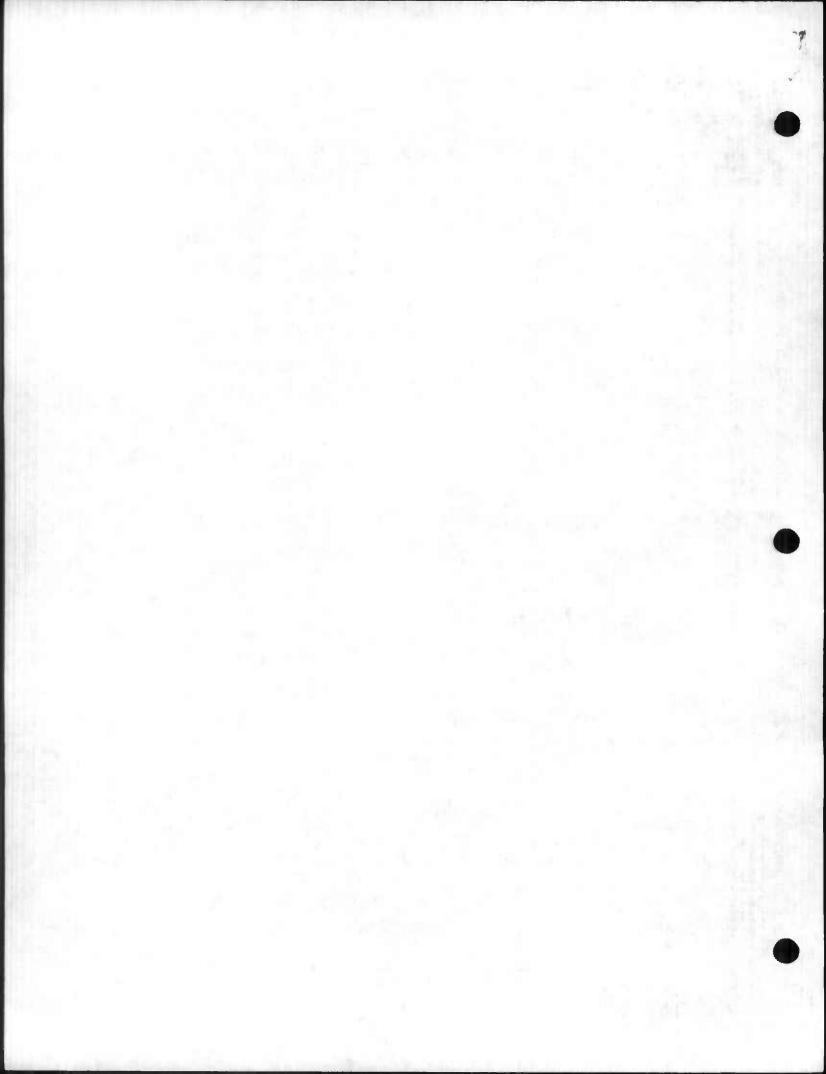
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37029

	1. Decedent's Neme	(First, Middle, L	ast)				te of		2. Dete of De	Reg. No. eth		3. Time of Deeth	
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	unknown Usuel Residence of D		1⊠M 2□F	7. Age (m	yrs. last birthe	Month:		Hours Min.	9-15-0	y, Year)	9. Birti	nplece (Stete or Foreign untry) MD	
1		10b. County		100	City, Town o	r Location		73 7 3				10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
Director	MD			I	Baltimo								
10	10e. Street and Numb	oer .				10f. 2	ip Code			10g. Citizen of	f What Co	untry?	
Funeral	309 N. M	ain Str						21639			USA		
1	11. Meritel Status		12. Was Dec		in U,S.	13. Was Dec	edent of lecify Cub	Hispanic Origin? (Spoen, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	eck, White	rican Indien, e, etc.	
	1 ☐ Never Merried 3 ☐ Widowed 4		1 Tes If Yes, G Yeer or I	2 No live Detes:				Specify:		Spec		Other	
	(0.1	5. Decedent's I	Education		16a. D	ecedent's Us	ual Occu	pation	ula a	16b. Kind of	Business/I	Industry	
	(Specify		rede completed	(1-4or 5+)	(6	Give kind of v fe. DO NOT	use retire	during most of worked)	ang				
	N?A	, (3/	N/				N/	/A			N/A		
1	17. Fether's Neme (F	irst, Middle, Las	st)					18. Mother's Nam	e (First, Middle,	Meiden Sume	eme)		
	Unknown							Naila Ya	doop				
	19e. tnforment's Nam	ne/Reletionship	(Type, Print)		19b. A	Neiting Addre	ss (Stree	t end Number or Ru	-	er, City or Tow	n, State, Z	Pip Code)	
	Naila Ya	goob/Mo	ther		300	N. M:	ain 9	StP, Bal	timore	Md. 2	1639		
1	20a. Method of Dispo		-11-1	2	Ob. Place of D	isposition (N	eme of		Dete	20c. Location		Town, State	
	1 Burial 2					cremetory or			0///00	D. 144		MJ	
once.	4 □ Donetion 5			sal	Johns H			•	0/4/00	Baltim	ore,	Md.	
1	21. Signature of Funeral Service Licenses 22. Name end Address of Fecility JHH-600 N. Wofle St. 21287 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,												
+	23e. Pert1. Enter the		Approximete										
ian	shock, or heert Immediate Cause (Fi		y one ceuse on	eech iine.							1	Intervel Between Onset and Death	
1.3	Immediate Cause (Final disease or condition resulting in deeth) e. CARDIOVASCULAR SHOCK Due to (or ex e consequence of):											TWENTY HOU	
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	that initieted events resulting in death) Le		CAF	RDIAC	to (or es e cor ISCHEM	nsequence of			TWEN				
1			d						TWINT				
-	Pert II. Other elgnific	ant conditions	contribution to	deeth but no	t resulting in t	ne underlying	cause n	iven in Pert I	23b. Did	tobacco use o	ontributa	to the cause of death	
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	DEDIN	ATAI DE	חחדפפדס						_	_		of death?	
Pe Complete	FERIN	AIAL DE	PRESSIO	N					150	Yes 2□No		1 ☐ Yes 2☐ No	
		d to medicat	Unanital.				100	26. Place of Des	th (Check only	one)			
3 2	25. Wes case referre examiner?		Hospitel:		2 ER/Outp	ne of	28c. Inju	ury et	ome 5 Resi 28d. Describe			city)	
1	examiner? 1 ☐ Yes 2 ☑ No 27. Menner of Death		28a. Dete	of Injury	ar) Ini		f 28c. Injury et Work? M 1 □ Yes 2 □ No						
1	examiner? 1 ☐ Yes 2 ☑ N	o 5 □ Pending investigati	28a. Dete (Mo	e of Injury onth, Dey Yea	ar) Inje		1 _	Yes 2 No		28f. Location (Street end Number or Rurel Route Number, City or Town, State)			
99 01	examiner? 1 ☐ Yes 2 ☑ No 27. Menner of Death 1 ☑ Neturel	5 Pending	28a. Dete (Mon	nth, Dey Ye	At home, ferm	М					mber or Au	urel Route Number,	
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DHMH 16 Rev 6/95



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

					Certi	ficate of	Death			Reg.	No.		, 00	
5h!-!	1. Decedent's Name (First, Middle, Last,)	1397					2. Date of D Month		Day	Year	3. Time of D	eath
Physician / Medical	Roy	R.	N	Nave					NOVEH				1:23	PM
Examiner	4a Facility Name (If n	ot institution, give	street and number)				4b. City, Tow	n, or Lo	cation of Dea	ith	4c. County	of Death		
		BULLNE					BALT				BALT	IMOR:	E	
Funeral	5. Social Security Nun	4.0	x 7. Age	e (In yrs. last t		If Under 1 Year Months Days		4 Hrs. Min.	8. Date of Bi	irth	ar)	9. Birthp	lace (State or F	oreign
irector	367-28-673 Usual Residence of D	04		78	113.				12-22-	172	1		III	
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinet must be notified at once. To Be Completed by Funeral Director		0b. County		10c. City, To	wn or Local	tion						1	0d. Inside City	Limits
To Ten	Maryland	Baltimon	e	F	Baltim	nore							1 🗆 Yes 2	No
Director	10e. Street and Numb	er				10f. Zip Code				10g.	Citizen of	Whet Coun	itry?	
a =	8144 Bulli	neck Road	1			212	222			Uni	ted S	tates	5	
riner must.	11. Marital Status		12. Was Decedent E Armed Forces?	Ever in U,S.	13. Wa	s Decedent of les, specify Cub	Hispanic Origi	in? (Spe	city Yes or N	0-		ce - Americ		
F.	1 Never Married		1 X Yes 2 □ N If Yes, Give	o WW II		Yes 2 No		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	11047, 010.7		Specif	Wh:		
d by	3 Widowed 4	Divorced	Year or Dates:											
Completed		Decedent's Edu only highest grad		16	(Give kin	nt's Usuel Occu	during most	of worki	ng	16b	. Kind of B	usiness/Inc	dustry	
dm	Elementary/Second	ary (0-12)	College (1-4or 5 n/a	+)		NOT use retire				Sp	arrov	s Po:	int	
	17. Father's Name (Fi	rst. Middle, Last)	,				_	's Name	(First, Middle	1				
To Be		ave					Lilli	ian	Fletc	her		•		
-	19a. Informent's Nam	e/Retationship (T)	rpe, Print)	19	9b. Mailing	Address (Stree	t and Number	or Aura	il Route Num	ber, Ci	ty or Town,	State, Zip	Code)	
	William H.	Nave (So	on)	23	32 Dor	ncaster	Rd Jor	ppat	owne,	MD	2108	35		
į	20a. Method of Dispos			20b. Placa cemer	of Dispositi	ion (Name of tory or other pla	ace)		Date	200	. Location	City or To	wn, State	
1		Cremation 3 ∐ F ☐ Other (Specify)	lemoval from State		-	emetery		1	1-22	Ba1	timo	ce, Ma	aryland	
- Suce	21. Signature of Funa	Service Licens	90		22. N	lame and Addr	ess of Facility		harra T	Zanan o	1 I	Iomo	Tno	
8	M	And I				adley-A							1222	
	23a. Part1. Enter the shock, or heart	cases or compl	ications that caused	the death. De									Approximate Interval Between	000
ian	Shook, 2 hadi	Danie. List only of	io dadoo on odon iii	10.								1	Onset and De	ath
cal	Immediate Cause (Fit disease or condition	nal		Luna	CON	ncer						1	4mo	nths
ner	resulting in death)		1.	Due to (or as								i		
Examiner			D									i		
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	cause. Enter Underly Cause (Disease or Inj thet initieted events	ina 📕	ò									i		
edicai	resulting in death) Las	st		Due to (or as a	a conseque	nce of):						1		
2			J											
Physician/	Part II. Other significa	ent conditions cor	tributing to death bu	ut not resulting	in the unde	eriving cause gi	iven in Pert I.		23b. Did	d toba	cco usa co	ntribute to	the cause of	death?
hys						,,					2□ No		bably 4□Ui	
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		Coxon	my and	-	dica	050			24a. Wa	s an a		av	ere eutopsy fine ailable prior to	
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Completed									1□	Yes	2 19 No	10	Yes 2 N	0
Be (25. Was case referred examiner?	to medical					26. Place	of Death	(Check only	one)				
2	1 Yes 2 No)	lospital: 1 Inpatie	nt 2 ER/C	Outpatient	3LI DUA		sing Ho	me 5 PAes	sidence	9 6 □Oth	ner (Specif	y)	
on: To Be C	27. Manner of Death	5 Pending	28e. Date of Injur (Month, Day	Year) 28b	. Time of Injury	28c. Inju			28d. Describe	how i	njury occur	rred		
cati	2 Accident	Investigation 6 Could not be					Yes 2 N			10.				
Certification:	4 ☐ Homicide	determined	28e. Plece of Injubution		farm, street	t, factory, office			281. Location City or To			ber or Hurs	il Route Numbe	er,
2	29e. Certifier 1	Carlibian Di	lofen: To the best	of man beauty 4	no doesh -	coursed at the t	ima date	Diese	and due to the	0.00	a(c) and	00001 00 0	teted	
completely filled in by the funer Medical Certification	(Check only 2	Medical Exami	nar: On the best of and manner sta	examination a	and/or inves	stigetion, in my	opinion, death	n occurr	ed at the time	e, date	and place,	and due to	the cause(s)	
2	29b. Signature and titl	e of certifier	l			29c. Licen	se number			29d.	Date signe	ed (Month,	Day, Year)	
1	1 Xch	a Mi	ester	M.D		AV	4635	542	7		1112	010	0	
L	30. Name and address	of person who co	mpleted cause of de	eath (Item 23e) (Type Pri			-				-		
X	Λ	MURTH			GRE		TREET	,	BALT	IM	ORE	, MD	2120	1
State	31. Date filed (Month,			ar's Signature		and the same		•		•		-		
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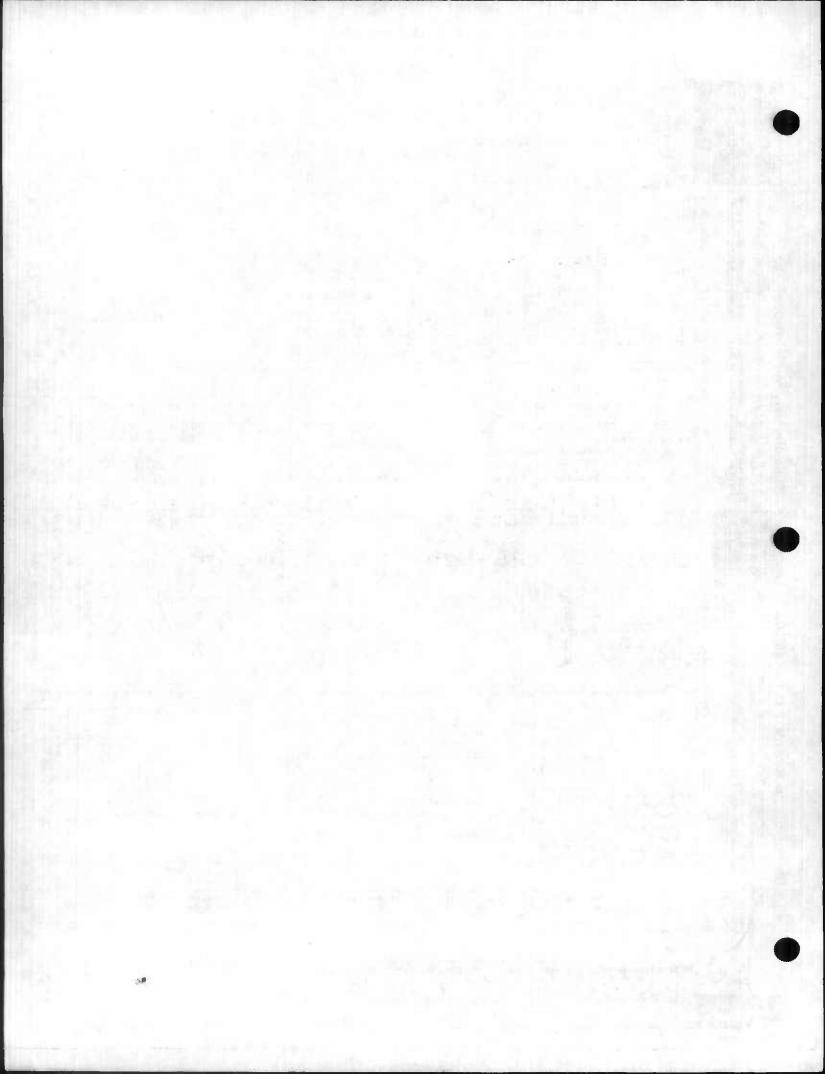
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State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Bea Mary Nooe 18 Nov. 2000 8:20AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) North March 8,1914 Carolina 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 20X Yrs. 237-12-2918 86 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits iene.
Than "natural", or itema 23a or 28a-f abov the Medical Examinar must be notified at XXYes 2 □ No Directo Maryland N/A Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1302 Pontiac Avenue Funeral 21225 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 華 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) 88 should be and Mental is marked Hugh E. Summers Sallie Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is m any Injury or other traum price. 1554 Long Point Road Pasadena, MD 21122 Walter Nooe, Jr. (Son) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 11/22/00 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home, P.A. 4001 Ritchie Hwy Baltimore, MD 21225 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical ocardia Examiner Due to (or as a consequence of): Physician/Medical Examiner The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician and d be detached for use as the buriel-trer Box 68760. Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Uhknown p 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed this certificate has 1 Yes 1 ☐ Yes 2 ☐ No initial or Attending Physician: The control of the Be 25. Was casa referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Wother (Specify) 1 Yes 2 10 Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Author St. fibura 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Neme and address of parson who completed cause of death (Item 23a) (Typa, Print) Severnatark Jennifer 479 clum 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar **DHMH 16 Rev 6/95**

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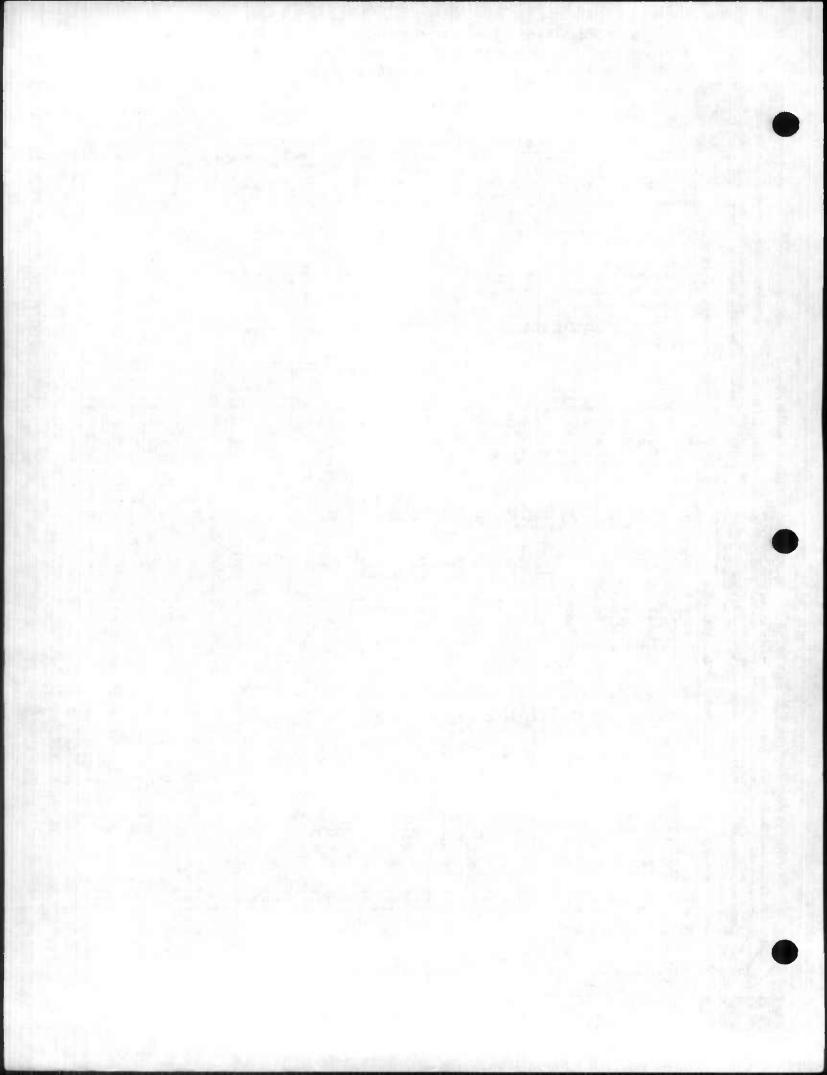
Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Mary Agnes O'Brien November 14, 2000 3:20 P.M. /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mariner Health Care of Glen Burnie Glen Burnie Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□M 2⊠F Days Hours 218 26 1132 90 Yrs. Ohio April 1, 1910 Director Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 5322 Fourth Street 21225 U.S. Funeral death v 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. "natural", or items 11. Maritet Status filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No by Specify: White 3 X Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12th other i 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 end 2 should be nent of Health end Mentel ant: If them 27 is marked o Lillian (not available) John Haarman 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health er Important: if item 27 la any injury or other trace James Rychwalski / Grandson 5322 Fourth Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Glen Haven Memorial Park 11/17/00 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensia 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Pert1. Enter the disease, or complications that of used the death Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical tmmediete Cause (Finel disease or condition resulting in death) ATHEROSCUEROSIC GENZEALIZED Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the deeth certificata be axecuted ng physician end as the burial-transit Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, is certificata has been signed by the attending physician director, page 2 should be detached for use as the buria Due to (or as e consequence of) P.O. | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? SEIZURE DISORDER 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? STEOARTH ZETIS this certificata has DEMENTIA 1 Yes 2 No 1 Yes 2 No nat or Attending Physician: The after death.

It Director: After this certificate of in by the funeral director, pa 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4K Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturat 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Wed in by 4 ☐ Homicide Within Samples 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end magner stated. Medical 29a. Certifier å 29d. Date signed (Month, Dey, Year) 29b. Signeture and Jittle of certif 29c. License number 30. Neme and address of person who completed gause of death (Item 23a) (Type, Print) KICHARD ISHER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

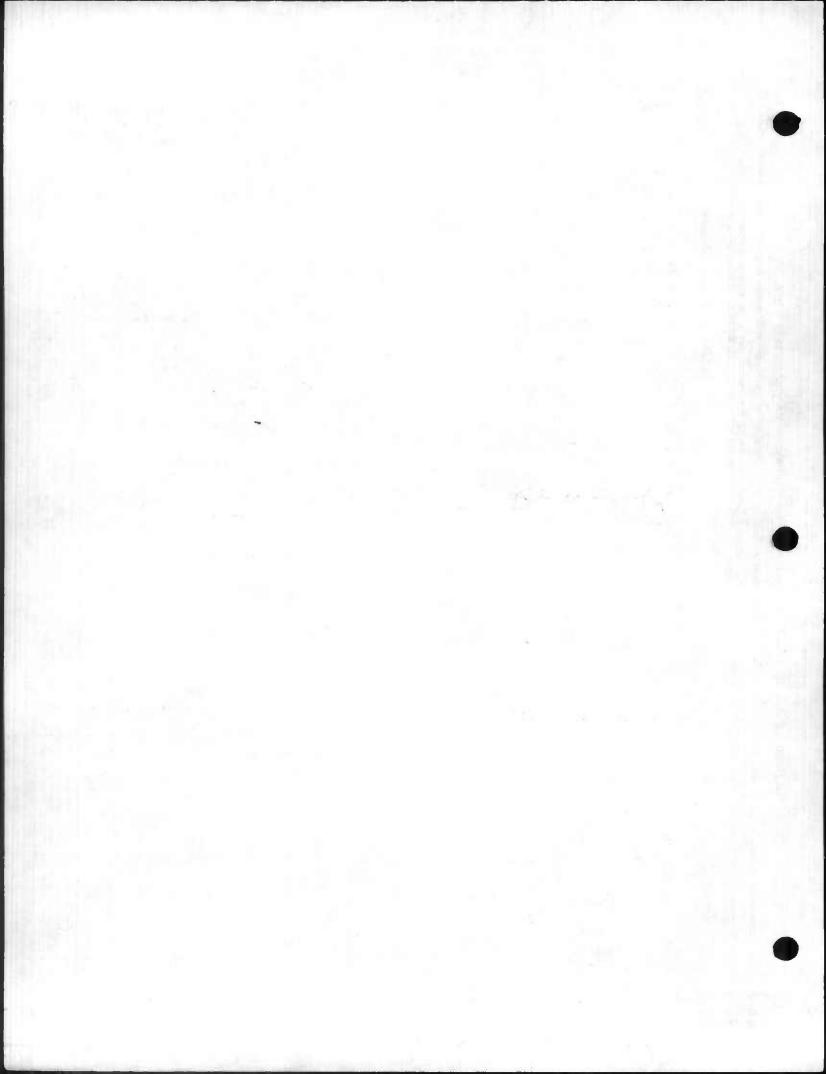
Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day TH Year Month **Physician** JUAN JO FRANCES 10.30 P NOVEMBER 16 2000 /Medical 4e Facility Nema (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE. KANDALLSTOWN HOSPITAL CENTER. NORTHWEST If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) If Under 1 Yeer 8. Deta of Birth (Month, Day, Year)

Dec. 18, 1924

9. Birthplaca (Stata or Foraign Country)

West Virginia 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 KF Yrs. 234-40-3536 75 Director Usual Rasidenca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore Baltimore Director w 23s or 21s-f must be notifie 96 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 2827 Rona Road 21207 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 11. Merital Status permit. Pages 1 and 2 should be flied within 72 hours after Department of Health and Mental Hygones in processer, if teen 27 is nestleed other than "neturel", or the any injury or other traumetic event, the Manicol E 1 Never Merried 2 Married 1 ☐ Yas 2 ☒No If Yas, Give altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: à 3 N Widowed 4 Divorced Yaar or Dates: White Completed Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health Care Finance Elamentary/Secondary (0-12) Coilega (1-4or 5+) -0-12th Grade Clerk Administration 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be William Luther Simmons Myra Alice Mitchell 19a. tnformant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mr. Michael C. Oland - Son 5927 Oakland Road; Eldersburg, Maryland 21784 20b. Place of Disposition (Nama of cematary, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 Buriat 2 □ Cremation 3 □ Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Lake View Memorial Park 11/20/2000 Sykesville, Maryland 21. Signatura of Funaral Sarvice Licensea 22. Nama and Addrass of Facility Loring Byers Funeral Directors, Inc. M00869 8728 Liberty Road; Randallstown, Maryland 21133 as a. H 23a. Part I chtar tha disaasa, or complications that caused tha daath. Do not antar the mode of dying, such es cardiec or respiretory errest, shock, or heer failura. List only ona cause on aech lina. Approximete Intervat Batween Onsat and Death **Physician** /Medical Immediata Causa (Final . INTRA CEREBRAL HEMORRHAGE disease or condition rasulting in death) Examiner Dua to (or as a consequenca of): Examiner The law requires that the death certificata be executed Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medicai the Due to (or as a consequanca of) USB BS Part tl. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? page 2 should be detac 1 Yaa 2 No 3 Probably 4 Unknown TALEULION. Division of Vital Records, P 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate 1 ☐ Yas 2 No 1 Yas 2 No Attending Physician: funeral director, 8 25. Was casa rafarred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA this 28e. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred 28c. tnjury at Work? 5 Pending invastigation After 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident if or Attend after death Director: / 6 Could not be datamined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) B 4 Homicide To the Hospital or within 24 hours att 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifier (Check only one) NoV- 16TH - 2000 29b. Signatura and title of certifiar 29c. Licansa number 42723 onich HOSPITAL CENTER 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) NORTHWEST AVVERAHALLI HARISH . mD 211 33 RANDALISTOWN 31. Data filed (Month, Day, Year) 32. Registrar's Signetura State NOV 2 2 2000 Registrar

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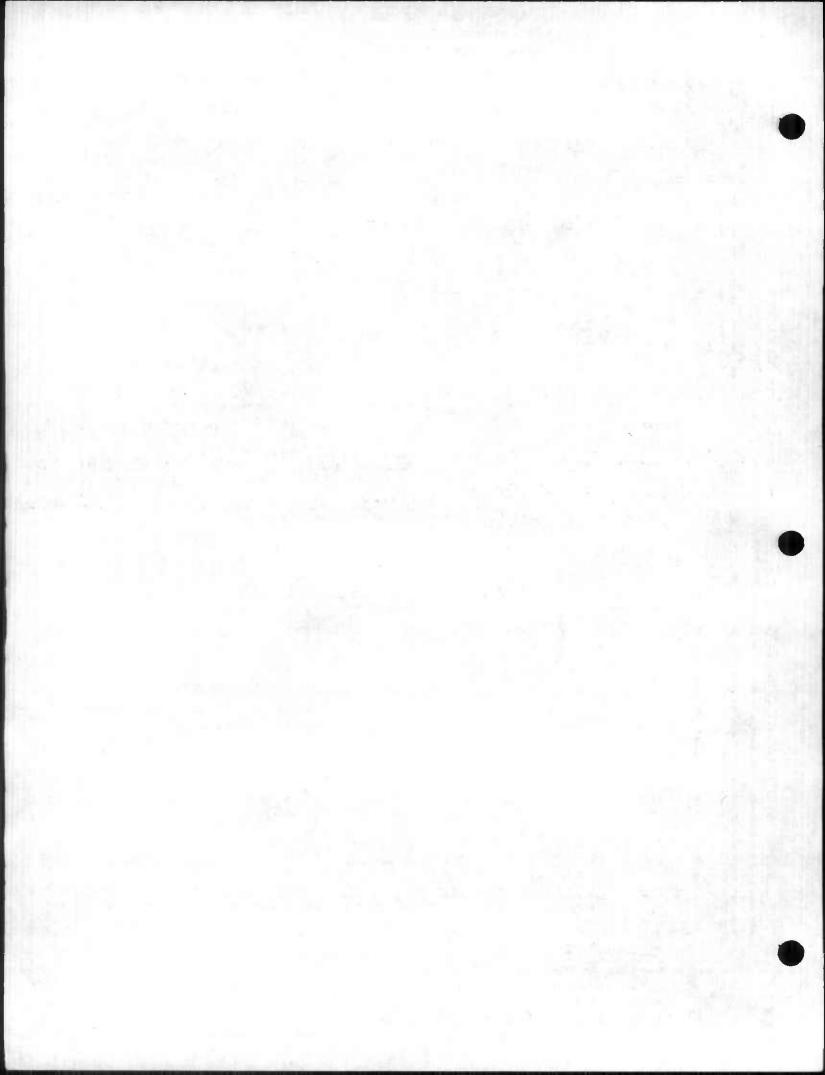
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Day Year **Physician** 1050 AM MARGOARET PELLE NOV MARY 9000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not Institution, give street and number) **Examiner** SAMARITHN NURSING BALTIMORE
If Under 24 Hrs. 8. Date CTR If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Deys 10 M 20 F Min. Hours 95 29,1904 Director 217-26-0494 MARYLAND Usual Residence of Decedent with the Manyland d 2 should be filled within 72 hours after death with the Marylan th and Mental Hygiene.
7 is marked other than "natural", or Rema 23a or 28e-f ehow tranmatic avent, the Medical Exemples, man be notified as 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo PERRY HULL MD BALTIMORE 10e. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? 21236 J.S.A 103 A Funeral 19 JULIET 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Maryland 21215-0036 à 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC permit. Pages 1 and 2 should be filled. Department of Health and Mental Herrimportant: if hem 27 is meany injury or other. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) MINNIE WILLIAM TRAGESER ROSENTITAU 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. #103 PERRYHALL, MD. 21236 DONALD PEUE SON 19 JULIET 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete NOV. 22, 1 Burial 2 Cremetion 3 Removel from Stete CHAPPEL 4 ☐ Donation 5 ☐ Other (Specify) 2000 FOREST HILL 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility EVAN'S FUNDEAL CHAPEL TOWX ZI MD. 21234 HARFORD Es. PARKVILLE 23a. Part. Enter the disease, or complications that oused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only she ceuse or each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner physician and s the burlal-transit law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): for use as 82 ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed t þ 24b. Were eutopsy findings available prior to completion of cause of death? should b 24a. Wes en eutopsy performed? Completed page 2 s 1 Yes 2 3 No 1 Tyes 2PINO certificate Division of Vital Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After or Attending 1 Neturel 5 Pending investigation thin 24 hours after deeth.

the Funeral Director: Alempletely filled in by the fu deeth. 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner steted. within 2 To the f 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) ANISA MD 5601 PAVEN BLUD. BALTIMORE, MD 21239 MIRZA LOCH 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registra NOV 2 2 oaks

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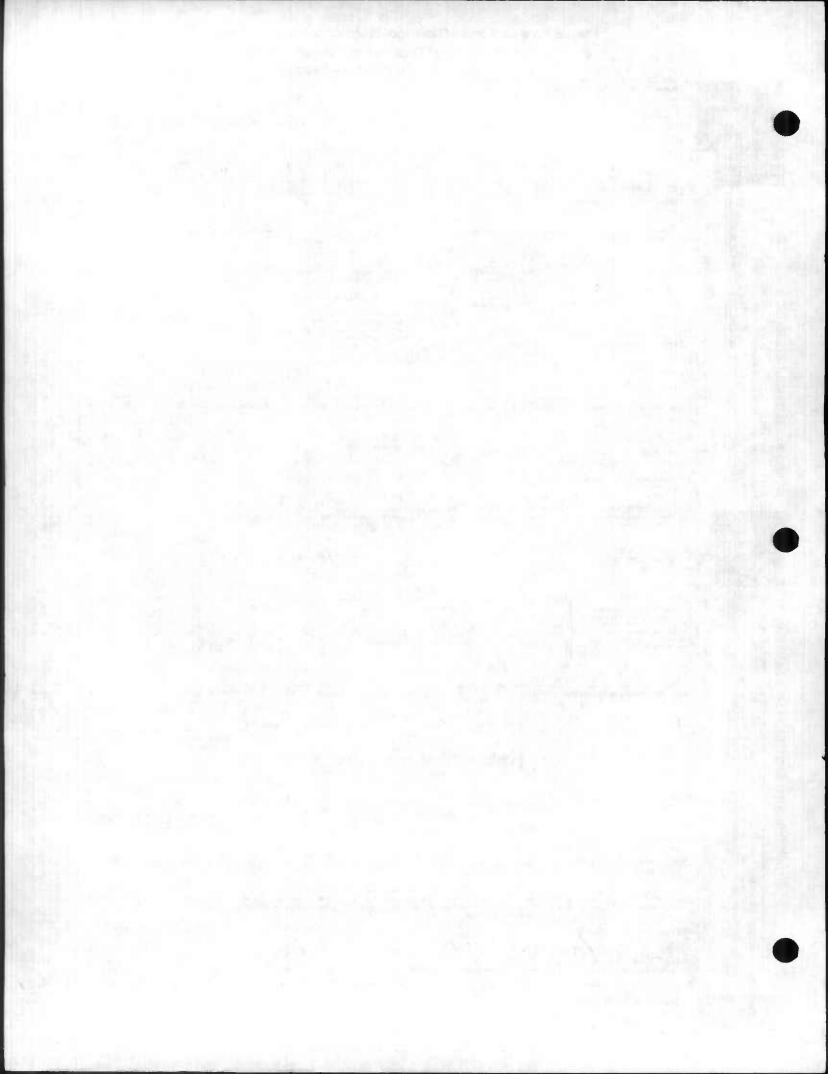


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State of Maryland / Department of Health and Mental Hygiene 37036

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19e. Informant's NamorRelationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town. 35 20th Perez / Husband 20th Perez of Disposition (Name of Emiletry, cremetory or other place) 20th Learner of Emiletry (Premetory or Other place) 21 Signeture of Funeral Service Licensee 22 Name and Address of Feelility Fleck Funeral Laurel, Maryland National Cem. 11/28 Laurel, Maryland National Ce	
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21. Signeture of Funeral Service Licensee 22. Neme and Address of Fecility 7601 Sandy Spring Road, Laurel, M 7601 Sandy Spring Road, Laurel, M 23a. Pert Letter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Immediate Cause (Final disease or conditions resulting in death) Sequentially list conditions, if any, feeding to immediate cause, Enter Underlying that initiated events. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): ATRIAL FIBRILLATION 24e. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical evantine? 1 Yes 2 No 25. Was case referred to medical evantine? 1 Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death 1 Naturat 5 Pending investigation 28e. Date of Injury 28b. Time of liny 28c. Date of Injury 28b. Time of liny 28c. Date of Injury 28b. Date of Injury 28b. Location, (Street and Number) 28b. Loca	
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25. Wes case referred to medical examiner? Second Se	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
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building, etc. (Specify)	or Rural Route Number,
29a. Certifier (Check only Control of the basis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menr (Check only Check only 20 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, date end placa, end	er as stated. If due to the cause(s)
29b. Signature and title of cartifler 29c. License number 29d. Dete signed 11-21	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTO AFRICANO, MID 344 UNIVERSITY BLVD W, SKLVER SPI State 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture	LING, MD 209

cc



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death ROBINSON 5:20 PM 2000 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) County of Death HOSPITAL BAUTMORE Utimore Cit AGNE If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) Yrs. 34 June 6,2000 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location Baltimore Yes 2 No ND 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ate La 21220 207 42N Was Decedent Ever in U,S. Armed Forces?

1 Yes, Giva 13. Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status Bleck, Whita, etc Never Married 2 Merried Black 1□ Yas 20 No Specify Specify: If Yes, Giva Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) faut College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumaria) Angelo ٣ Melissa Kobinsoh 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 307 N. Chapelqate La. Balto HD21229 Informant's Name/Belationship (Type, Print) Melissa (mother Robinson 20b. Place of Disposition (Nama of commany, crematory or other place)
New Cathedral Cemetary 20a. Method of Disposition Data 20c. Location - City or Town, State Burial 2 Cremation 3 Removal Irom Stata Donation 5 Other (Specify) 10/06/2000 Ballo Ha 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licenses agues Healthlare 900 Caton Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. tmmediata Cause (Finat disease or condition resulting in death) SEPSIS 48 HOURS Dua to (or as a consequence of): PROMATURITY TREME Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy lindings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yas 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case refarred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yas 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

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Completed

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Funeral

Director

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or items 23s.

permit. Pegas 1 and 2 should be filed within 72 hours effer to Department of Heelth and Manial Hygienn.
Important: If fram 27 is marked other than "natural", or then any injury or other treumatic avant, the Medical Examinat

Baltimore, Maryland 21215-0020

Examiner physician and the burial-transit Physician/Medical Š Completed funeral director, 8 Certification: To

Records, P.O. Box 68760, Division of Vitai or Attending Physicien; After this ofter deeth Director: 24 hours To the Hosp within 24 hos To the Fune completely fi

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State Registrar

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, end dua to tha cause(s) end mannar as stated.

2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

5 Pending investigation

engeeeeeming

29c. License number D29475

1 Yas 2 No

29d. Data signed (Month, Day, Year) JULY

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

40 Name and address of perfort who completed cause of death (Item 23a) (Type, Print) ST AGUES HOSP 17741

HOWAND T. BIRENISANM, M.D. 800 CAFON AUDIU HOWAND

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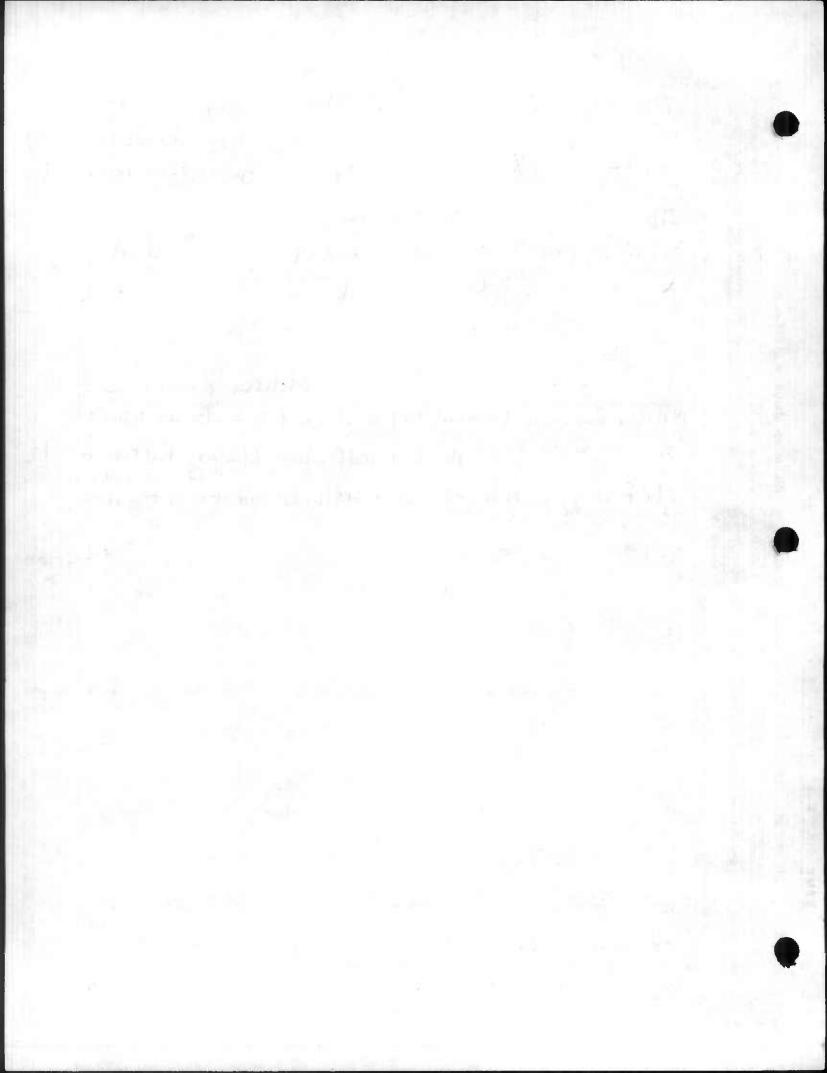
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1 Natural

2 Accident

3 Suicide

32. Registrar's Signatura



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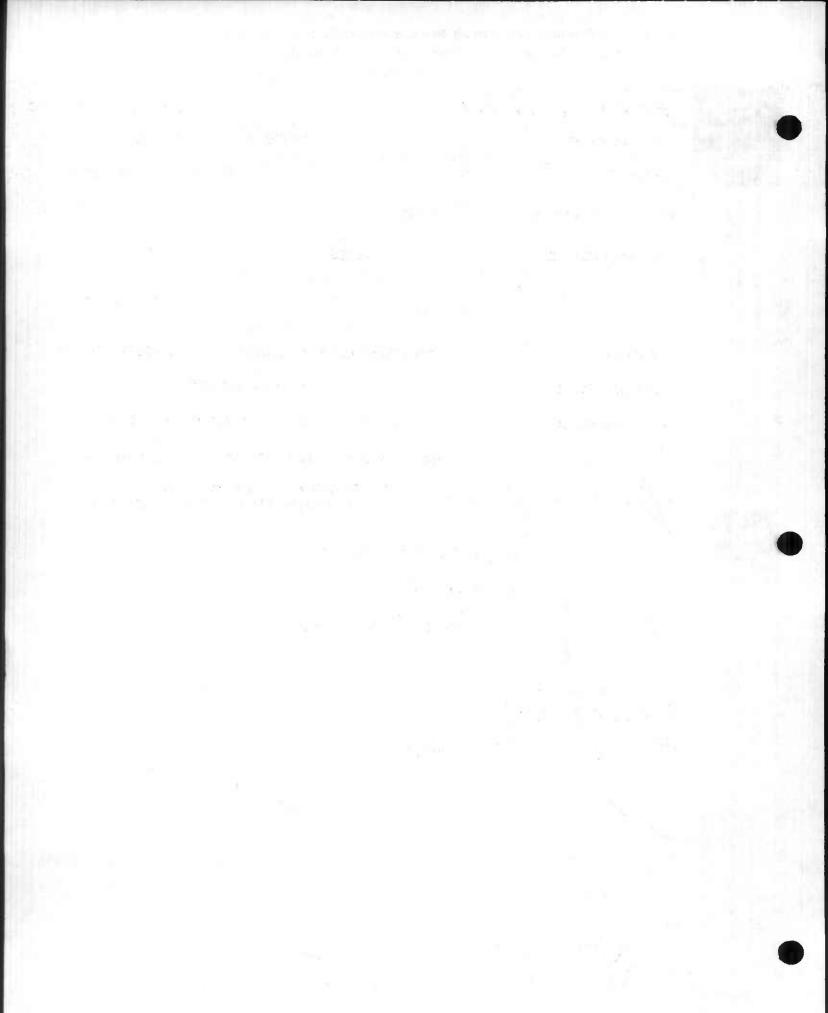
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month Vaar **Physician** ICKELI RANCIS 30 00 11 20 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** BALTIMORE KERNAN CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day (ear) 5/10/39 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country)
 NEW YORK **Funeral** Months Deys Hours 12 M 2□ F 61 **Vrs** Director 104-32-2439 Usual Residence of Decedent the Maryland 10e State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Modical Examinat must be notified at MD BALTIMORE TOWSON 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 1613 ABERDEEN ROAD 21286 USA death Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 LaYes 2 □ No If Yes, Give Year or Detes: VIETNAM Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. nit. Pages 1 end 2 should be filed within 72 hours efter carment of Heelih end Mental tygiene.
ortant: If item 27 is marked other than "natural", or itel injury or other traumatic event, the Medical Example. 1 Never Married 2 Merried Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementery/Secondary (0-12) College (1-4or 5+) NSCSA AMERICA EOUIPMENT CONTROL MANAGER 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LUCILLE SULLIVAN FRANCIS PICKELL 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) BALTIMORE, MD 21286 WIFE 1613 ABERDEEN ROAD VIRGINIA PICKELL Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Remove from State permit. Page Department of Important: If any Injury or MORELAND MEMORIAL PARK 11/22/00 HILLENDALE, MD 4 Doneylog 5 Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility THE JOHNSON FUNERAL HOME, P.A. au 8521 LOCH RAVEN BLVD. TOWSON, MD TM. Enter the disease, or complication whet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, like, or haert failure. List only one groups on aech line. Approximele Intervel Between Onset end Deeth **Physician** /Medical Immedieta Causa (Final diseese or condition rasulting in deeth) Examiner Due to (or es e consequence of Examiner physician end s the buriel-transit Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Undarlying Ceusa (Disaase or Injury that initieted evants resulting in death) Lest Due to (oras a consequence of) Box 68760. 80 Physician/Medicai Due to (or es e consequence, of attending 50 P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? the been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown Records, P Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death? 2 PNo 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes cese referred to medical exeminar? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? To the Hospital or Attending I within 24 hours effer death.

To the Funeral Director: After 5 Panding Investigation 1 Natural 1 Yes 2 No 2 Accident illed in by the 3 ☐ Sulcida 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homleide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated. edicai 29e. Certifian completely (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed ceuse of deeth (Item 23a) (Type, Print) envan

32. Registrar's Signetu

DHMH 16 Rev 6/95

State Registrar 31. Date filad (Month



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State of Maryland / Do

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		1. Decedent'a Name (First, Middle,	ast)		2. Date of De Month	ath Day	Year	3. Time of Death				
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	Examiner	4a Facility Name (If not institution, g				4b. City, Town, or L	ocation of Death	th 4c. County of Death				
T.		INNER LOOP 1695	at CROSBY ROAD			WOODLAWN		BALT	IMORE			
	Funeral	5. Social Security Number 6		. last birthday)	If Under 1 Year		8. Date of Bir (Month, Da	th Vent	9. Birthp	lace (State or Foreign		
	Director	217-34-7559	¥ M 2□ F 65	Yrs.	Months Days	Hours Min.		4,1935		**		
	7	Usual Residence of Decedent					rial 2	471233				
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Baltimore	Department of important: If any injury or pace.	21. Signature of Funeral Service Lic		22	2. Name and Addre	ess of Facility		Arbutu:				
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Ö	at the death cert d by the attendin letached for use Physiclan/N	Part II. Other significant conditions	contributing to death out not re	suting in the u	nderlying cause gr	ven in Fart t.		Yee 2 No		bably 4 Unknow		
0	= 00						,,,	100 2U NO	3_110	DECHY 4 OHAIOM		
Vital Records,	een signe hould be d							an autopsy	24b. W	ere autopsy tindings		
Ö	The law require sate has been single 2 should Completed						perfe	ormed?	CC	mpletion of ceuse		
360	has has mp							/ _		death?		
ie i	cate he cate he Com						10	Yes 2□ No	1N	ØYes 2□No		
/ita	Physician: The this certificate ral director, page TO Be Co	25. Was case referred to medical examiner?	Manager		100	28. Place of Dea	th (Check only	one)				
of	hys his lidi	1 □X es 2 □ No		☐ ER/Outpatie	NI 3LI DUA			idence 6 XOth		b) SCENE		
2	Bu en co	27. Menner of Deeth 1 Netural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wo	ork?		how injury occur		lievele		
Division	ttanding death. stor: Atter y the fune	2 Accident Investigation	11 10 00	Approx 8:	30M 1L	Yes 2 No				Y VEHICLE (S		
ž	r Att ler d rect rect rect rby	3 Suicide 6 Could no determine		home, tarm, st	reet, tactory, office		City or To	wn, Stete)		el Route Number,		
0	No Hospital or Attanding P n 24 hours after death. Funeral Director: After t pletely filled in by the funeral edical Certification:			DWAY			There	or 695,B	AUTIL	wrt co tho		
	L hour uner uner cal	29e. Certifier 1 Certifying (Check only 2 Medicat Ex	Physician: To the best of my kr aminer: On the basis of examir	owledge, deat	h occurred at the ti	ime, dete and place	and due to the	ceuse(s) end m	anner as s	iteted. o the cause(s)		
		one) A	and manner stated.									
	To the com	29b. Signature and title of certifier	A (D)		29c. Licen			29d. Date signe				
	N	Mounte	The Thill	IUM.	0.0	.M.E.		NOVEMBI	cr 1/	, 2000		
	Sh	30. Name and address of person with	o completed cause of death (Ite	em 23a) (Type,	Print)	4 1 1 1 1 1 1						

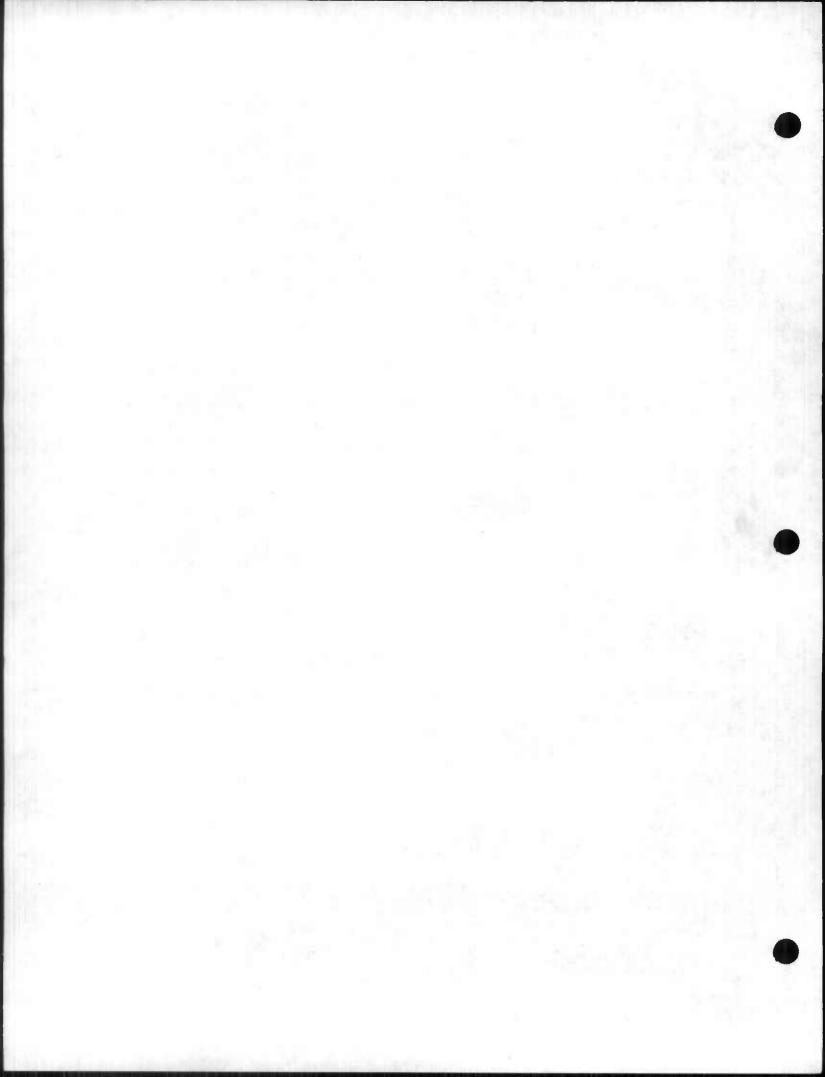
State Registrar

31. Date filed (Month, Day, Year)
NOV 2 2 2000

1. KOREW

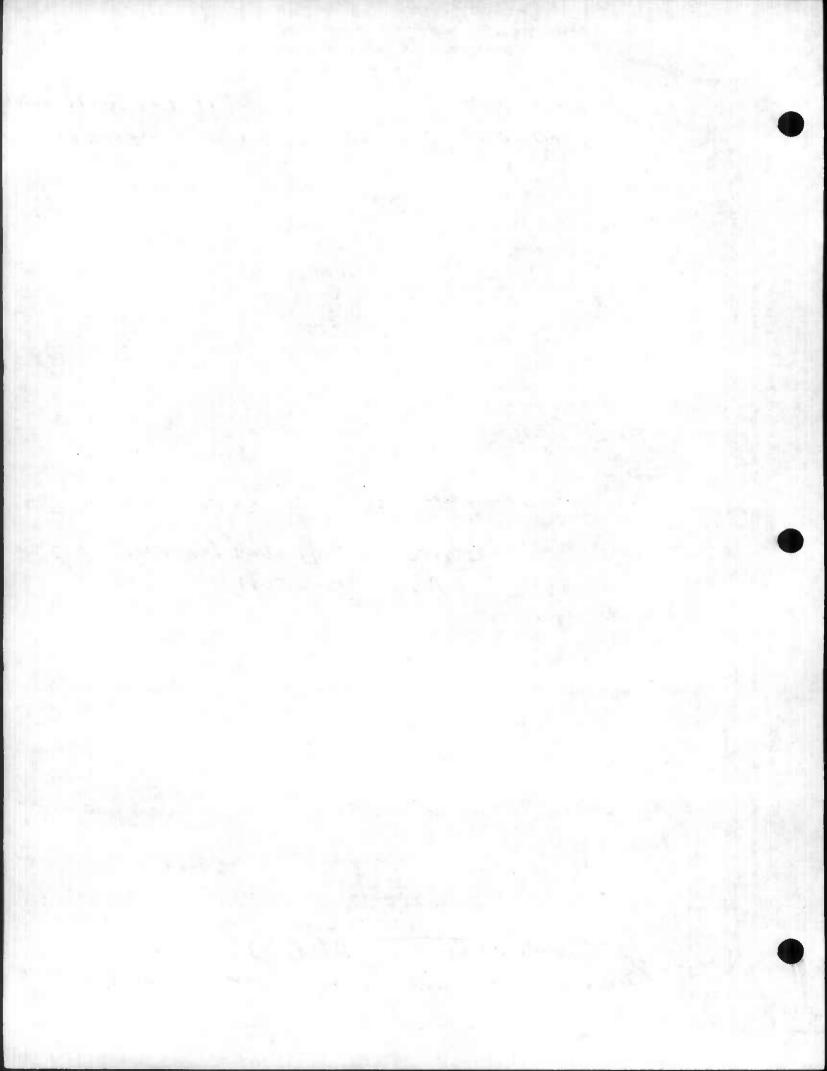
32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37040

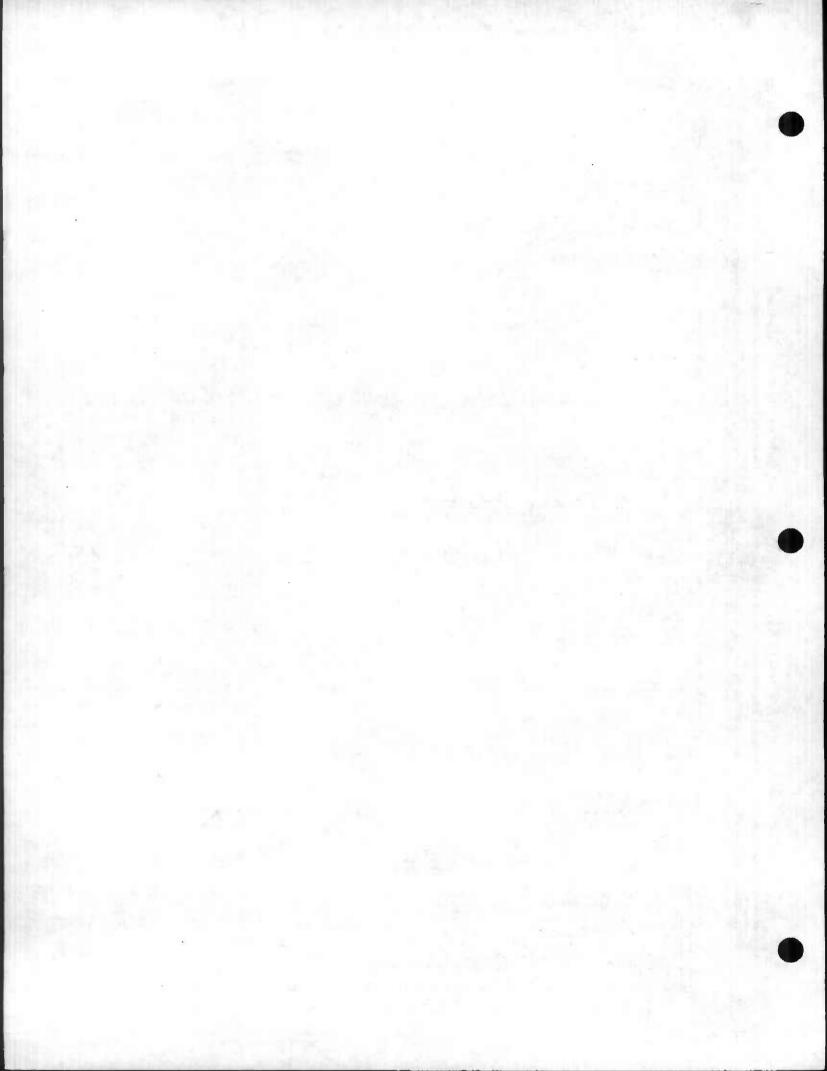
Certificate of Death		Reg. No.							
1. Decedent's Name (First, Middle, Last) H12MA KAY	2. Dete of Dea	Day 16 24	Year 1	ima of Death					
5. Social Security Number 6. Sex 1 M 20 F 78 Yrs. Months Deys Hours Min.	n BIA	Ho	WARI	Stele or Foreign					
10a. State 10b. County 10c. City, Town or Location 10c Maryland Howard Columbia									
106. Street and Number 106. Zip Code 21045			,						
11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 9-9-43 If Yes, Cive Year or Dates: 3-19-46 13. Was Decedent of Hispenic Origin? (Specify Cuban, Mexican, Puerto Yes, Cive Year or Dates: 3-19-46	ecity Yes or No- Rican, etc.)		k, White, etc.	en,					
10 College (1-40r5+) Telephone Operator		Bell A	Itlantic						
19e. Informant's Name/Relationship (Type, Print) Charles Edward Ray/son 19b. Mailing Address (Street end Number or Rur 7030 Flint Feet Lane	el Route Numbe Columbi	a, Maryl	2and 210	145					
1 Burlel 2 Cremetion 3 Removet from State 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility	88 <u>0</u> 21-								
trimediate Cause (Finel disease or condition resulting in death) a. Sequentielly list conditions, if any, leeding to immediate cause. Enter Underthying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or es e consequence of): Due to (or es e consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	of her	nerrbz	R	120					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.		all Probably	ause of death?						
	24a. Wes	an autopsy med?	available	prior to on of ceuse					
aversine?			1 🗆 Yes	2 No					
1 Yes 2 No Hospitat: 1 Inpatient 2 Fr/Outpatient 3 DOA Other: 4 Nursing Holder Nursing Holder Accident Nursing Holder 28e. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No No No No No No No		The state of the s							
29e. Certifier Cortifying Physician: To the basis of examinet: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.									
one) and manner stated.		29d Date sinne	d (Month, Day, Y	(ear)					
one) and manner stated.	9 (11/16	12000	2104					
	1. Decadent's Name (First, Middle, Last) 4. Facility Name (Irinst, Institution, give sheet end number) 4. Facility Name (Irinst Institution, give sheet end number) 4. Social Security Number 6. Sex 7. Age (In yrs. lest brindley) 10. City, Town or Location 10. Street and Number 10. Street and Number of the Street and Number or Income Street And Number Or In	1. Decedent's Name (First, Middle, Last) 2. Decedent's Name (First, Middle, Last) 4. City, Town, or Location of Death Vision (Control Page 1) 4. City, Town, or Location of Death Vision (Control Page 1) 4. City, Town, or Location of Death Vision (Control Page 1) 4. City, Town, or Location of Death Vision (Control Page 1) 4. City, Town, or Location of Death Vision (Control Page 1) 4. City, Town or Location (C	1. Decedent's Name (Final, Medde, Leat) 46. Facility Name (Final metalizion, plee street and number) 46. Cery, Yame (Final metalizion) plee street and number) 5. Social Security Name (Final metalizion) plee street and number) 5. Social Security Name (Final metalizion) plee street and number) 5. Social Security Name (Final metalizion) plee street and number) 6. Sex 1. Sex 2. Sex	Developed Name (Proc. Mode), Latt) A					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

				Cer	tificate	e of L	Death		R	eg. No.		
ician	1. Decedent's Nema (First, Middla, La	rst)							2. Deta of Deal Month	th Day	Year	3. Tima of Death
ician dical	Lois		Rei	d					Nov. 1	7, 200		14:40pr
niner	4a Facility Nama (If not institution, give								ation of Death	4c. County	of Death	
	1010 St.Paul		-		If I Indee	1	Balti Undar 2				A	
21		Sex 7. 1 □ M 2 🕱 F		last birthdey) Yrs.	If Under 1 Months	Deys	Hours	Min.	8. Dete of Birth (Month, Day	Year)		olaca (Stete or Forei otry)
or	Usuet Residence of Decedent		87			_			08-05-	13	N	C
	10a. State 10b. County		10c. Cit	y, Town or Loc	cation				101/2		1	0d. fnside City Limi
tor	NC NA		В	altimo	ore							1∏ Yes 2□ N
Funeral Director	10e. Street and Number				10f. Zip (Coda			1	0g. Citizen of 1	What Cour	ntry?
a	1010 St. Paul	Street	Apt.	10-N	2	2120)2			USA	A	
0	11. Marital Status	12. Was Decede	ent Evar in U	,S. 13. W	Vas Decede	ent of Hi	ispanic Orig	pin? (Sper	city Yas or No- Rican, etc.)		e - Amaric	can Indian,
	1 Never Merried 2 Married	Armed Force 1 Yes 2	No		☐ Yes ≱		Specify:			Specif		410.
	X8 Widowed 4 □ Divorced	Yeer or Dete	es:								Bl	ack
Completed	15. Decedent's E (Specify only highast gr			16a. Deced (Give I	lant's Usuet kind of work	k done	ation during most f)	of workin	working 16b. Kind o		f Business/Industry	
	Elamentery/Secondery (0-12)	College (1-4	or 5+)				"			1 .	- l	
	6th Grade 17. Fether's Name (First, Middle, Last	NA		Don	nesti	LC	18 Mother	r's Nama	(First, Middle,	somels		ome
Be			8 13								10)	
2	Caleb 19a. Informant's Neme/Raletionship	Round	tree	10h Mailin	a Addrass	(Street	Leit			Jones	Stata 7in	Code) 2120
	John Reid	туре, глин)										imore, MI
	20e. Method of Disposition		20b. F	Plece of Dispos	sition (Nam	na of				20c. Location		
	1 Burial 2 Cremetion 3		919	cemetery, crem							3	
any injury or once.	4 ☐ Donetion 5 ☐ Other (Special 21. Signature of Funeral Service Lice	••					Garde ss of Fecility		11-25-	-2000	Dunc	lalk,MD
	21. Signature of Furieral Service Lice							Ba				d 21202
	23a. Part1. Enter the disease, or comshock, or heert failure. List only		one						01 E.		Ave	nue Approximata
Jei	Immediate Cause (Finel disease or condition resulting In death)	· Hy	Due to (15/01 or as a consequ	uence of);		7	1				>5-104/4
CAGIIIITE	Sequentially list conditions, if any, leading to immediate cause. Enlar Underlying Cause (Disease or injury C.											
edica	Cause (Diseese or injury that initiated events resulting in death) Lest	c	Dua to (o	to (or as a consequence of):								
Physician/M		d										
SICIB	Part II. Other significant conditions of	contributing to death but not resulting in the underlying causa given in Part I.					23b. Did tobacco use contribute to the cause				o the cause of dear	
Ě		contributing to death but not resulting in the underlying causa givan in Part I.						1 Yes 2 国No 3 Probably 4 日				
2					Line Comment						_	
Completed									24e. Wes e perfor	n autopsy med?	av.	ara autopsy finding reileble prior to
ble	E-1211 / 2	1	~		_42						of	ompletion of causa death?
000									1□ Y	es 22 No	1	Yes 2 No
Be	25. Was case referred to medical axaminer?							of Deeth	(Check only or	na)		
2	1 ☐ Yes 2 No	Hospitel: 1 Inp		ER/Outpatien			4 LI NO	rsing Hon	ne 5 Resid	enca 6 □Otl	her (Speci	(hr)
on:	27. Manner of Deeth 1 Natural 5 Pending	28a. Data of (Month,	Dey Year)	28b. Tima of fnjury		8c. Injur			28d. Describe h	ow injury occu	rred	
Certification:	2 Accident investigetion 3 Suicide 6 Could not be determined	28a. Plece of	f fnjury - At h I, etc. <i>(Speci</i> l	oma, ferm, stra by)	M aat, fectory,		Yas 2□f		28f. Location (S City or Tow		ber or Run	al Route Number,
1		nyelcian: To the besi	is of examina									
		and menne	r steted.		29c.	Licans	e number			29d. Date signe	ed (Month,	Day, Year)
	29b. Signature and this of certifier		* Spingson							1		
edica	29b. Signature and this of certifier	VI	m. I		7	>-	2017			1 1	11	2000
Medical	Arel hundon	Legle	m.L),			3517			hovemb	ex 20	,2000
Medical	29b. Signature and mig of certifier 30. Nama and address of parson who	completed cause	M. Lof daeth (Iter	m 23a) (Typa, f					MD 21	hovemb	ex 20	,2000

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** TSABEL. NOVEMBER 18, ROSENBLUM 1:30 PM 2000 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 2712 BARTOL AVENUE BALTIMORE N/A If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys 1 ☐ M 2 🛛 F 178-14-2055 Yrs Director JUL.30,1910 PA Usuel Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 1 N Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10a. Citizen of Whet Country? 10f. Zip Code 2712 BARTOL AVENUE 21209 U.S.A. Funeral death 14. Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 Yes 2 No
If Yes, Give
Yeer or Detes: filed withIn 72 hours aftar 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify: p 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed will Department of Haalih and Mental Hyglen, Important: if item 27 is marked other tha any injury or other traumatic event, that once. HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be WILLIAM **GREENBAUM** CELIA SCHULHOF 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) CAROLE KATZ / DAUGHTER 2712 BARTOL AVENUE - BALTIMORE, MD 21209 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 X Removel from Stete TEMPLE BETH ISRAEL 4 Donation 11/21/00 FARRELL, PA 5 Other (Specify 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximete Intervel Between Onset end Death thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, OTH **Physician** /Medical Immediate Cause (Finel Myocardia Interro 5 min diseese or condition resulting in deeth) Examiner Examiner signed by the attending physician and die datached for use as the bunal-transit The law requires that the death cartificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or es e conseguence of): P.0. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy parformed? Completed peen paga 2 cartificata has 1 Yes 2 E No 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred I Director: Aftar the d in by the funera 28b. Time of 28c. Injury et Work? Certification: or Attending 1 DNaturel 5 Pending investigation 1 Yes 2 No daath. 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours after To the Funeral Dire The certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) 29a. Certifier edical (Check only and ma 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifies

State Registrar Ellist

31. Date filed (Month, Dey, Year) NOV 2.2

DHMH 16 Rev 6/95

32. Registrer's Signeture

30. Neme end address of parson who completed cause of deeth (Item 23a) (Type, Print)

2000

Rothschild

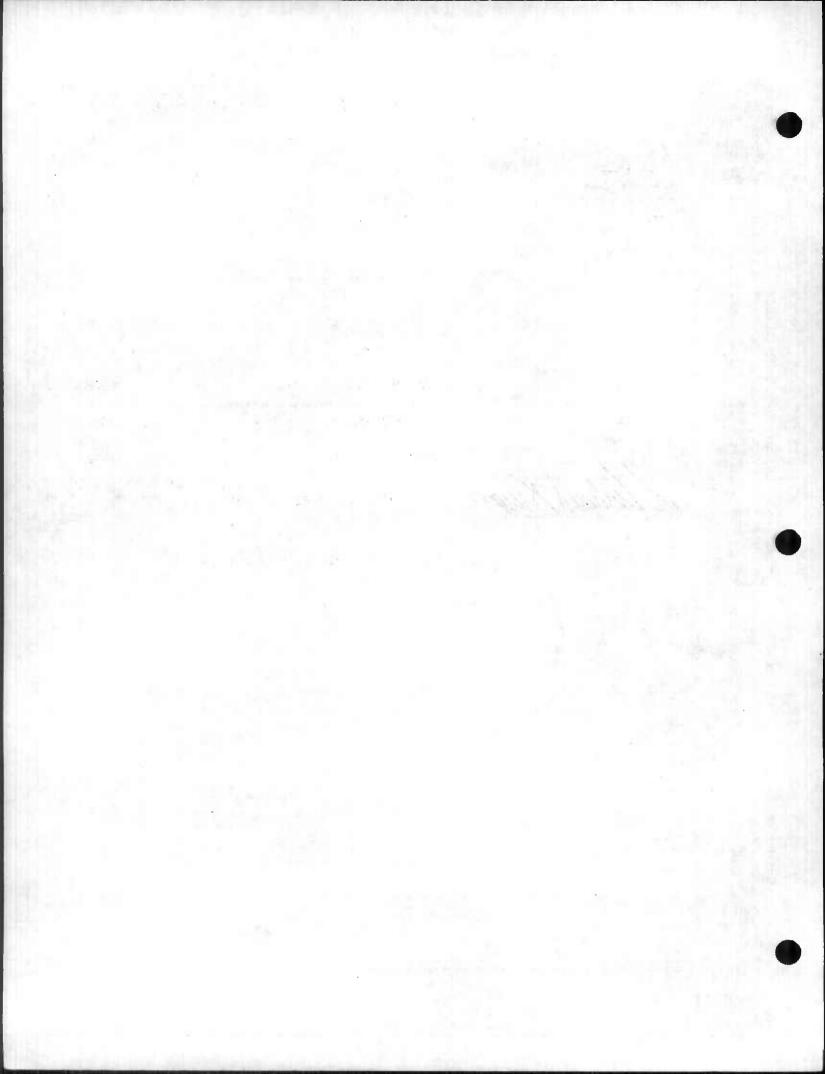
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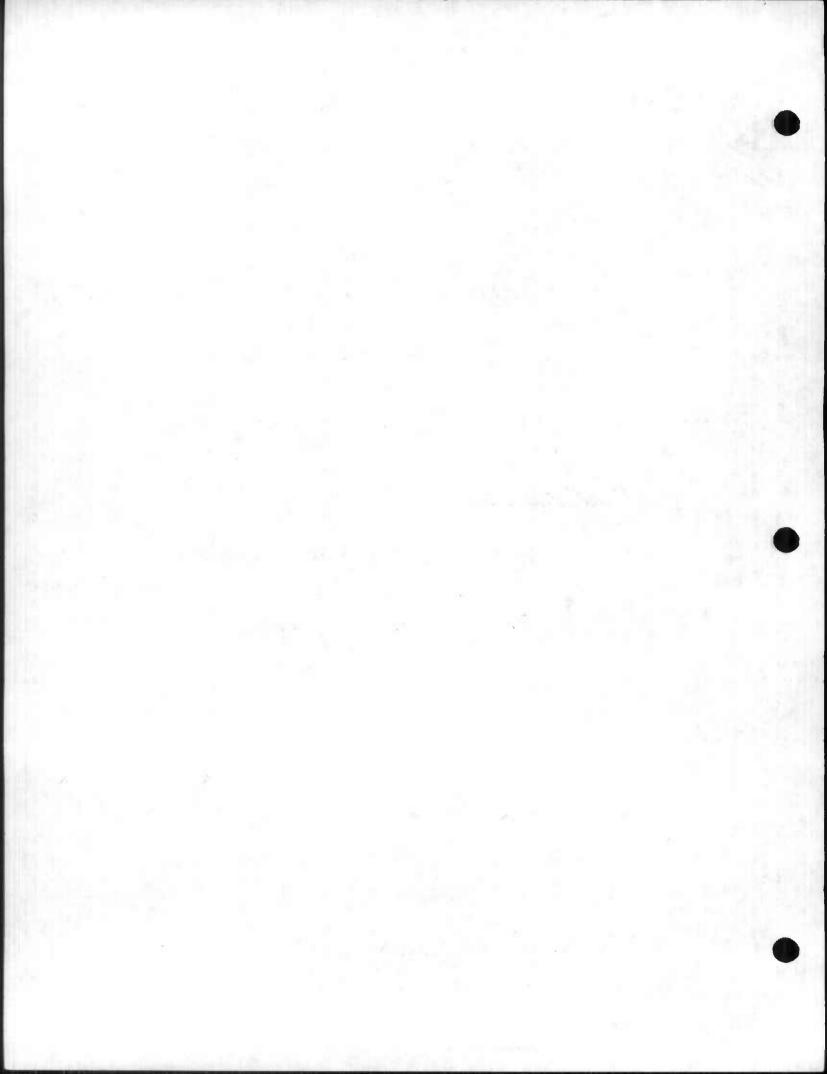
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State of Maryland / Department of Health and Mental Hygiene 37043

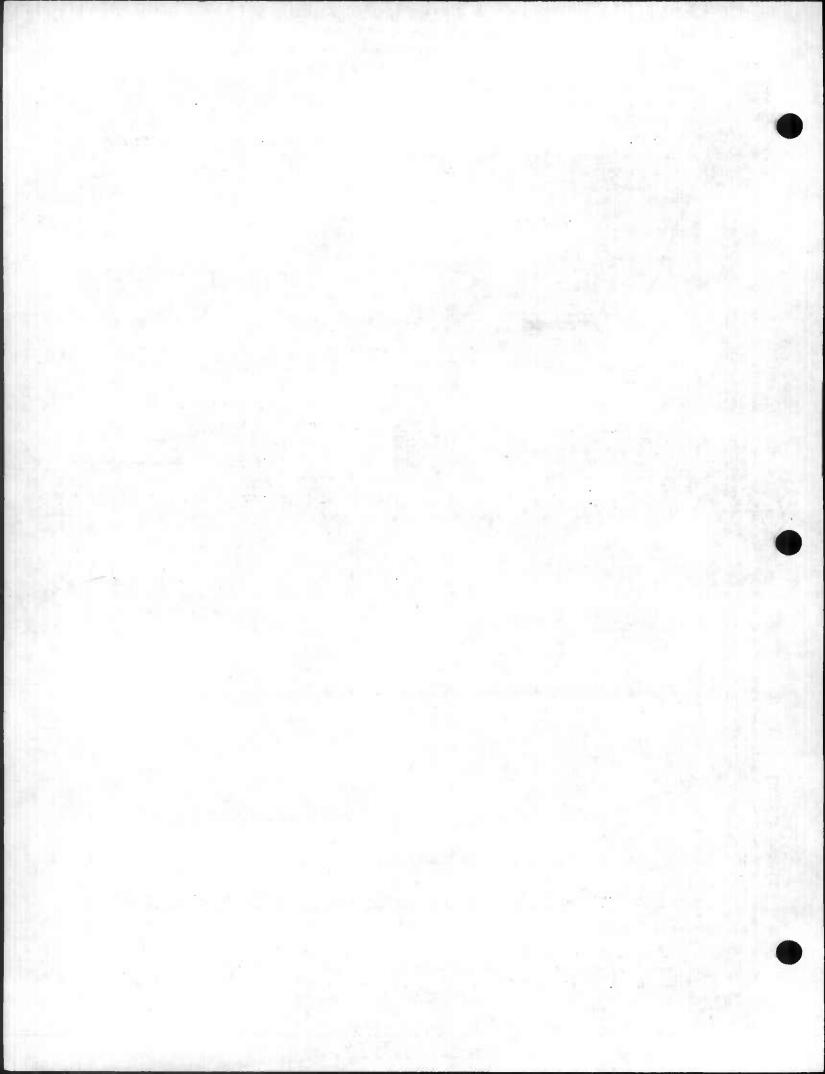
1. Decedent's Name (First, Middla, IRENE 4a Facility Name (If not institution, The Johns Ho. 5. Social Security Number 286-34-7348 Usual Residence of Decedent 10a. State 10b. County N. J. BURLIN 10e. Street and Number 54 SHEFFIELD 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced (Specify only highast Eternentary/Secondary (0-12) 17. Fether's Name (First, Middle, LIVICTOR G. POI 19a. Informant's Name/Relationshi EDGAR ROHRER (In the street and number) OKING HOS S. Sex 1 M 2 M F OTON DRIVE 12. Was Decedent Armed Forces? 1 Myes, Give Year or Datas: Education grada completed) College (1-4or S 2 Y R S	6 1 10c. City, Tow CC Ever in U.S. No	thday) If Under 1 Yaar Yrs. Months Days n or Location LUMBUS 10f. Zip Code 0 8 0 2	4b. City, Town, or Location BALTI MORE If Undar 24 Hrs. 8. De Hours Min. 0.8	ate of Birth pay, Year) 10g. Citiz USA	en of What Co 4. Race - Ama Black, White	hplace (State or Foreign untry) IO 10d. Inside City Limits 1 ☑ Yes 2 ☐ No untry?			
The Johns Ho. 5. Social Security Number 286-34-7348 Usual Residence of Decedent 10a. State 10b. County N.J. BURLIN 10e. Street and Number 54 SHEFFIELD 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced (Specify only highast Elementary/Secondary (0-12) 17. Fether's Name (First, Middle, LI VICTOR G. POI 19a. Informant's Name/Relationshi	DRIVE 12. Was Decedent Armed Forces? 1 Yes, Give Year or Datas: Education grada completed) College (1-4or 5 2 YRS	6 1 10c. City, Tow CC Ever in U.S. No	thday) If Under 1 Yaar Yrs. Months Days n or Location DLUMBUS 10f. Zip Code 0 8 0 2 13. Was Decedent of If Yes, specify Cub. 1 Yas 2 No Decedent's Usual Occup	PALH MORE 1 I Under 24 Hrs. 8. Da Hours Min. 0 8	ate of Birth pay, Year) 10g. Citiz USA	N/A 9. Birth CO OH sen of What Co 4. Race - Ama Black, White	hplace (State or Foreign untry) IO 10d. Inside City Limits 1 ☑ Yes 2 ☐ No untry?			
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17. Fether's Name (First, Middle, L. VICTOR G • POI 19a. Informant's Name/Relationshi	2YRS			during most of working	16b. Kin	d of Business/	industry			
VICTOR G. POI			-RAY TECH			ALTHC	ARE			
19a. Informant's Name/Relationshi	JOBILI			18. Mother's Name (Firs MARY SAN		Sumame)				
EDGAR ROHRER	p (Type, Print)	196	. Mailing Address (Street	and Number or Rural Rou		Town, State, 2	?ip Code)			
	HUSBAND)			LD DR. COL						
	ecify)	cemete		ATORY 11/2	2/2000		ON, N.J.			
William.	land		4905 YOR	K RD. BALT	0.,MD.	OMPANY 21212.				
23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused nly one causa on each li	the death. Do	not enter the moda of dyl	ng, such as cardiac or rasp	piratory arrest,		Approximate Interval Between Onsat and Death			
Immediate Cause (Finel disease or condition	Adult	Resi	natory Di	stress SI	nugrowe	2	2 months			
resulting in death)	Fin	Due to (or as a	and the state of t	0	1	3	2 months			
D										
resulting in death) Last										
Part II. Other significant condition		ut not resulting l	n the underlying cause gi	ven in Part I.	23b. Did tobacco	uae contribute	to the cause of death			
					1 Yee 2	□No 3□P	robably 4 Unknow			
				2	24a. Was an autop performed?	-/	Ware autopsy findings available prior to completion of cause of death?			
					1⊠Yes 2□	□ No	1 ☐ Yas 2 KNo			
25. Was case reterred to medical examiner?	Hospitel:		Ott	her:			**			
27. Menner of Death 1. Manual 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b.	Time of 28c. Inju	ry at 28d. [city)			
3 Suicide 6 Could no determin	ed 200. Place of inj		nm, street, fectory, office	281. L	ocation (Street and City or Town, State)	d Number or R	urel Route Number,			
	caminer: On the basis of	examination en								
29b. Signature and tale of certifier	4		29c. Licans	sa number	29d. Data	a signed (Mont	h, Day, Year)			
11/01/01/01/11	JUM SAMUL	hD., Oncol	BY Felby RES	2-000	Nove	uper 18	5,3000			
2	21. Signature of Funeral Service Li 23a. Par11. Enter the disease, or c shock, or heart failure. List of shock or heart failure. List of shock or heart failure. List of shock or high shock or heart failure. List of shock or high shock or heart failure. List of shock or h	23a. Part I. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each limmediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury their Initiated events resulting in death) Cause (Disease or Injury their Initiated events resulting in death) 25. Was case referred to medical examiner? 1	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on aach line. 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on aach line. Immediate Cause (Finel disease or conditions, if eny, leeding to immediate cause. Enter Undertying Cause (Disease or Injury the Initiated events resulting in death) Last Due to (or as a death of the cause of death but not resulting in death) Last Due to (or as a death of the cause of line) Due to (or as a death of the cause of death but not resulting in death) Last Due to (or as a death of the cause of line) Due to (or as a death of the cause of line) Due to (or as a death of the cause of line) Due to (or as a death of the cause of line) Due to (or as a death of the cause of line) Due to (or as a death of the cause of line) Due to (or as a death of the cause of line) 25. Was case reterred to medical examiner? 1	22. Name and Addre HENRY W. 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dylashock, or heart failure. List only one cause on each line. 22. Name and Addre HENRY W. 4905 YORN 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dylashock, or heart failure. List only one cause on each line. 24. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dylashock, or heart failure. List only one cause on each line. 25. Was consequence of): 26. Was case reterred to medical examiner? 27. Moner of Death 28. Date of Injury At home, ferm, street, fectory, office building, etc. (Specify) 28. Place of Injury - At home, ferm, street, fectory, office only one) 29. Signature and Addre HENRY W. 4905 YORN 29. Lican 29. Name and address of person who completed cause of death (Item 23a) (Type, Print)	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility HENRY W. JENKINS & 4905 YORK RD. BALT 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rass shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Add the conditions of the summer of the summ	Companies Comp	4 Contaion Check only one Case Check one Case Check only one Case Check only one Case Check one Case Check one Case Check one Check only one C			



State of Maryland / Department of Health and Mental Hygiene amend item 12,20c per fh G789 11/27/00 yf Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** NOVEMBER 14, 2000 HAROLD 12:45 PM ROTH /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 3705 GARDENVIEW ROAD BALTIMORE BALTIMORE If Undar 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, aug. 2, 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 85 294-10-5511 Director OHIO Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Directo BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? man be r 21208 USA 3705 GARDENVIEW RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No 17 Yes, Give Year or Datas: 2 TMY Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Rece - American Indian, r than "natural", or itse the Medical Examiner Black, Whita, atc. 1 Nevar Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PHYSICIAN MEDICAL 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middla, Last) Be Pages 1 and 2 should be nant of Health and Mental ant: If New 27 is marked of ROTH TDA HARRIS ABRAHAM 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) KELLY ROTH(WIFE) 3705 GARDENVIEW RD. BALTIMORE, MD21208 20b. Place of Disposition (Name of cematery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donatiop, 5 ☐ Other (Specify) Adelphi, Md 11/16/00 ADELPHÍA, MD MT. LEBANON 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 21. Signeture of Funeral Service License ellemen= 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel eumonia disaase or condition resulting in death) Examiner Examine physician end the buriel-transit death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseasa or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of) USB as t Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown Sculau Records, by 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed certificate has t 2 No 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitei: 1□ Yes 2⊡ No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) To 1 Inpetiant 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 1 Naturel 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Attending 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 5 Hospital 24 hours 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basia of examination end/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and manner stated. 29e. Certifier edicai To the Hosp within 24 ho To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 1838 WOV Coreque zdoward 31. Date filed (Month, Dey, Year) 32. Registran's Signeture State

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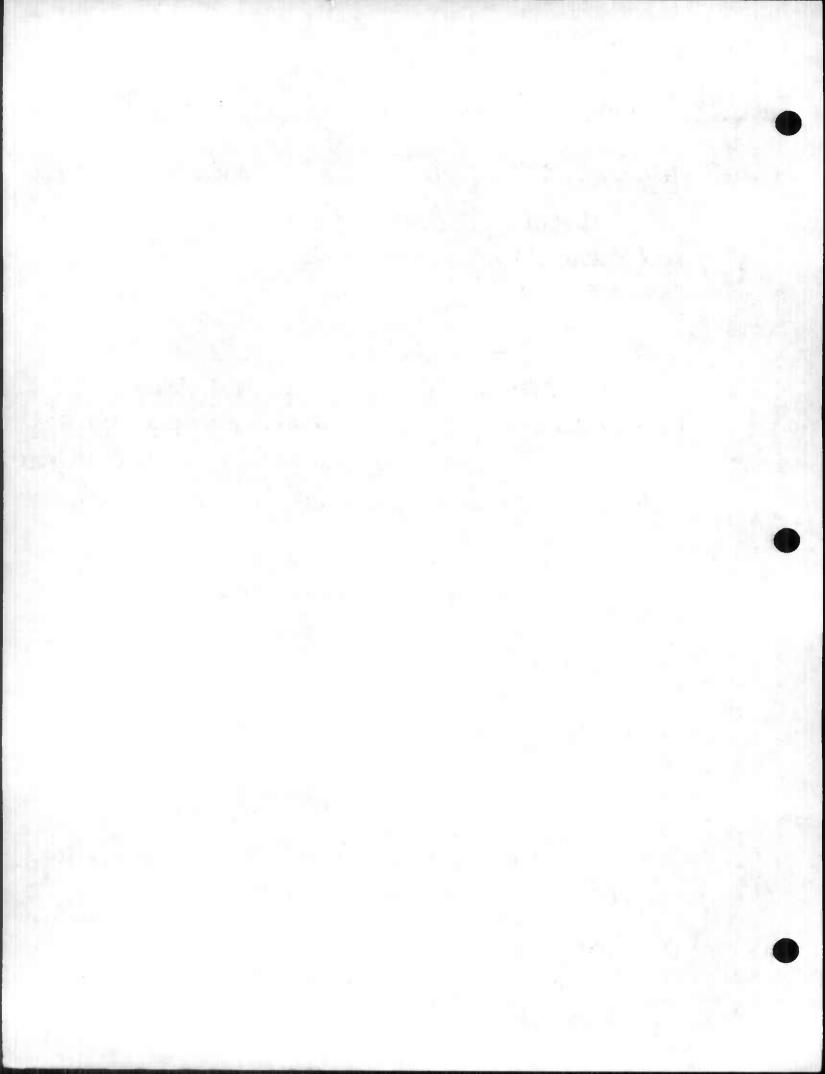
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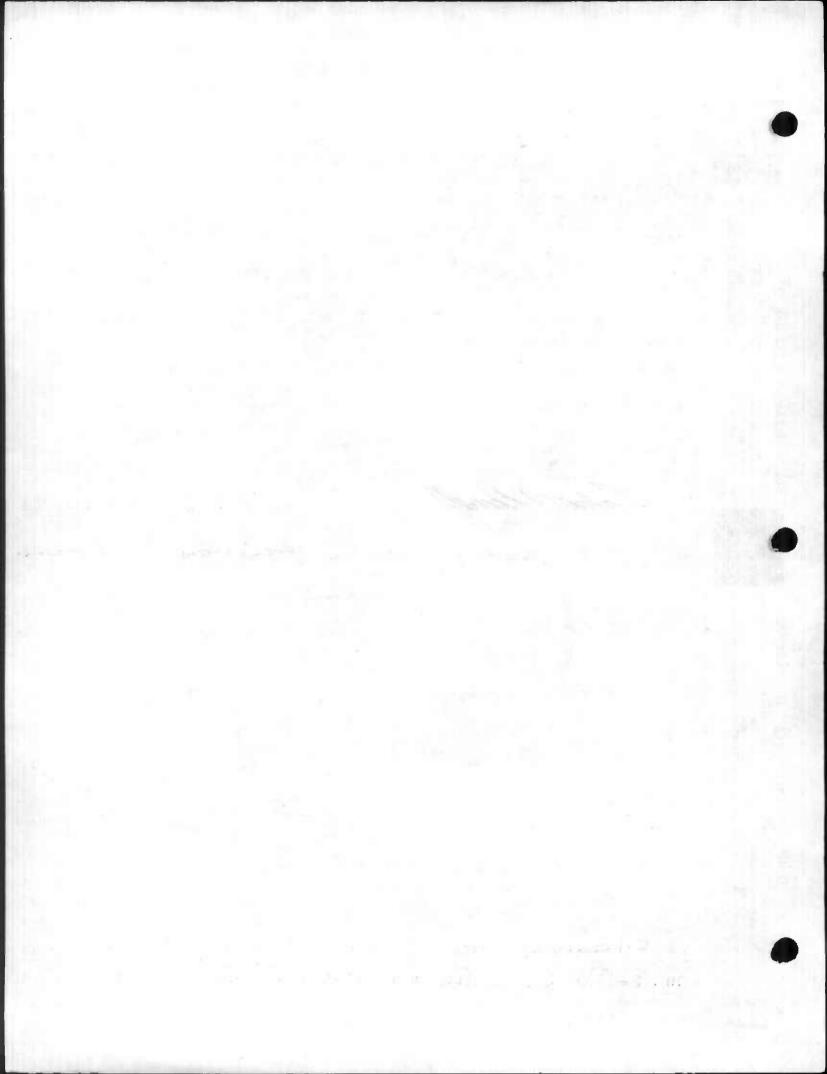
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	State of Maryland / Department of Health and Mental Hygiene	1

					Certificate of De	eath	Re	g. No.		
			1. Decedent's Neme (First, Middle, Last	2	,	2.	Date of Deeth Month		Vaar	3. Time of Death
	.Physicia /Medic		Lummy	Sandellin	SR.	I	Vovembe	r 16, 2	2000	846 am
	Examine	_	4a Facility Name (If not institution, give	street end number)	4b. 0	City, Town, or Locat	ion of Death	4c. County	of Death	
_			Upper Chesapeake			Bel Air		Harfo		
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last bit		Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Dey.	Year	9. Birthpl	ace (State or Foreign
	Director	K	Usual Residence of Decedent	40	110.		may 6	19601	MORY	u Carolloa
	hend wo	-	10a. State 10b. County	10c. City, Tow	n or Location				10	d. Inside City Limits
	Mary First	to	Md Haple	ed 80	lauron					1 ☐ Yes 2 No
	n the	9	10e. Street and Number	1 1	10f. Zip Code		10	g. Citizen of W	hat Count	ry?
	h wit		612 ARCOUN	WE.	2104			US	A	
	deat	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Specif Mexican, Puerto Ric	y Yes or No-		- America	
0	urs after death with the Marylen aff, or Items 23a or 28a-f show Examiner must be motified at		1 Never Married 2 Married	1 X Yes 2 No If Yes, Give	1.1	Specify:		Specify	1.11	ide
21215-0020	n 72 hours after death with the Manyland "natural", or thems 23a or 28a-f show points! Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						
15-	n 72 ha	Completed	15. Decedent's Edu (Specify only highest gred		Decedent's Usual Occupetio (Give kind of work done duning alife. DO NOT use retired)	ing most of working		6b. Kind of Bu	siness/ind	ustry
12	s within piene. r than "	E C	Elementery/Secondary (0-12)	College (1-4or 5+)	nhoop			The	400	
	Hygir Hygir ent,	O	17. Father's Name (First, Middle, Last)	1 1	18	3. Mother's Name (F	irst, Middle, M	aiden Sumem	Θ)	
lan	should be filed nd Mental Hyg marked other imatic event,	To Be	dimmi di	deplin SP		VOOW	CW	ASKO	(11)	
Maryland			19a. Informant's Name Relationship (T	rpe, Print) 198	. Mailing Address (Street and	Number or Rural R	loute Number,	City or Town,	State, Zip	Code)
Σ	17.		Thomas Askeu	SR. (012 LACOLUXX	SOL WR.	Edge	woo	M	21040
more	of the state of th		20a. Method of Disposition	comoto	f Disposition (Neme of ry, cremetory or other pleca)	. No	Date 2 2	Oc. Location -	City or To	wn, State
Ĕ	Pag ment mrt: It		1 Buriel 2 Cremetion 3 II 4 Donation 5 Other (Specify,	EVIUS	Funoral Chapel	-BOLLIE 2	000 P	OPAST S	Hell	Makulans
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۱	Physician									Onset and Death
4 3	/Medical Examiner		Immediate Cause (Final disease or condition	OCCLUSIVE PU	LMONARY EMI	BOLISM			i	
	- 4	-	resulting In death)	DEEP LEG	consequence of):				1	
	pei isc	Examiner				2KDB MD			1	
2	be executed sleien and burial-transit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a	consequence of):				I	
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68	g physical as the	edical	resulting in death) Last	Due to (or as a	consequence of):					
		2		d						
m	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/M	Part II. Other significant conditions co	ntributing to death but not resulting	n the underlying cause given	in Part I.	23b. Did to	bacco uss cor	tributs to	the cause of death?
P.0	that the de ed by the detached	hys					1 🗆 Yı	8 2 No	3 Prot	pably 4 Unknown
S, F	signed l	by								
Records,	v require been signal should t	P					24a. Was an	autopsy red?	ava	ere autopsy findings ailable prior to
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Œ.	The It	Completed					(DYe	s 2 No	Y	Ses 2□ No
ita		Be	25. Was case referred to medical examiner?			6. Place of Death (Check only on	a)	-	
of Vitai		2	1)X Yes 2 □ No	Hospital: Nonpatient 2☐ ER/O		4□ Nursing Home				y)
n o	ther the	on:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending		Time of lnjury at Work?		d. Describe ho	w injury occur	red	
Division	leeth. Ior: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be			s 2 No	Langtion (St	raataa d Alica b	or or Dure	J Pouto Number
N	fred Atrect Sirect In by	E	4 Homicide determined	28e. Placa of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28	City or Town		er or Hura	il Route Number,
	pital prailed	0	29a. Certifier 1□ Certifying Phy	alaban. To the beat of my less and a de-	a death assumed at the time.	data and place and	d due to the or	unn(n) and me	00000000	telad
	Hos 24 ho Fun stely	edical		sician: To the best of my knowledg ner: On the besis of examination el end menner stated.						
	To the Mospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	¥ F	29b. Signature and 4ftle of certifier //	A Mariner states.	29c. License n	number	2:	d. Date signe	d (Month,	Dey, Year)
	F≯Fŏ		1//	A Mi	2 o.c.	M.E.		Novembe	er 17	. 2000
	0 -		30. Name and address of person who c		n				J. 1	, 2000
	1			POUL, M. P.	111 Penn St	reet, Bal	timore	, Mary	Land	21201
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signature	-			- 4		
	Registra		NOV 2 2 2000	Berger P	Sparks					



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					•	tificate			vicitality	Reg. No.		
Physician	1. Decedent's Name	e (First, Middle, Las	t)						2. Date of De Month	ath Day	Year	3. Time of Death
/Medical	MAR		STASKO						NOV.	20,200	0	6:45 am
Examiner	4a Facility Name (I	If not institution, give	street and numb	er)			4b. City	, Town, or L	ocation of Deat	4c. County	of Death	
	HERIT.	AGE GERI	ATRIC	CENTI	ER			BALTI			LTIM	ORE
uneral rector	5. Social Security N 215-01-28 Usual Residence of	302	9X 7. □ M 2ÅF	Age (In yrs.	. last birthday) Yrs.	If Under 1 Y Months D	ear If Un ays Hou	der 24 Hrs. Irs Min.	8. Date of Bir (Month, Di June 1	th ly, Year) 3,1915		laca (State or Foreign try) YLAND
eff, or frame 23e or 28e-f show Essemble must be notified at by Funeral Director	10a. State	10b. County	MAG	10c. Ci	ity, Town or Lo	cation					10	0d. Inside City Limits
or 28s-f a be notified Director	MD.	N/A			BALTIM	ORE						NATes 2 No
Ole Dire	10e. Street and Nur	mber				10f. Zip Co	de			10g. Citizen of W	hat Count	try?
- E	2207 ESS	SEX STREET				212	231			U.S.A		
by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ied 2 Married	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	(1)(40		Wes Decedent f Yes, specify I ☐ Yes 2	Decedent of Hispanic Origin? (Specify Yes or s, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2XXNo Specify:			14. Race Black Specify:	- America k, White, e	etc.
peted	100.00	15. Decedent's Educity only highest grad	ucation		(Give	lent's Usual O kind of work d	one durina r	most of work	kina	16b. Kind of Bu		
Completed	Elementary/Seco		College (1-4	or 5+)	life. L	SSER	etired)			CLOTHI	NG	
O	17. Father's Neme	(First, Middle, Last)			1110	00210	18. M	other's Nam	ne (First, Middle	, Maiden Sumem		
To Be		STASKOWIA							LAWA NO			
Injury or other traumatic event, the Ma		eme/Reletionship (T								er, City or Town,		
		NDER/ SIS	STER	lee:				IE, BAL		MARYLAND		
8	20a. Method of Disg	oosition □ Cremetion 3 □I	Removal from Sta		Place of Dispo cemetery, crem	sition (Name on netory or other	r place)		Date	20c. Location -	City or To	wn, State
injury		5 ☐ Other (Specify,			. STAN	ISLAUS	CEMET	ERY 1	1/22/00	BALTIMO	RF.M	ARYLAND
any in	21. Signature of Fu	neral Service Licent	1/2	2	ML		ZEILE	R INC		AL HOME MORE, MAR	IZI A M	0 01021
sician edical miner	Immediete Cause (he disease, or comp rt feilure. List only o Finat n	one cause on eacl	h line.					or respiratory a			Approximate Interval Between Onset and Death
1	resulting in death)		a		or as a conseq						1	
s the buriel-transit edical Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	nditions, interesting	b	Due to (or as a conseq	uence of):			-			
	that initiated events resulting in death) t	Last	Due to (or as a consequence of): d									
Clai									1			
Physician/M	Part II. Other signifi	icant conditions co	ntributing to death	h but not res	sulting in the ur	nderlying caus	e given in P	art I.		1	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	the cause of death?
Completed by P	-									en autopsy omed?	cor	ere autopsy findings ailable prior to appletion of cause death?
E O									10	Yes 20 No		Yes 2 No
	25. Was case refer	red to medical					00.7	lines - C -				,
Be C	examiner?	/	Hospital:		1 80 10		-	4	th (Check only		45	
ation: To	1 Yes 2 2 2 27. Manner of Death 1 Netural 2 Accident	NO	1 ∐ Inpo		28b. Time of Injury		Injury et Work?			dence 6 □Othe how injury occurr)
Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		Injury - At h etc. (Speci	ome, farm, str	eet, factory, of	fice		28f. Location (City or To	Street end Numbe wn, Stete)	er or Rura	l Route Number,
edical	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exami	sician: To the be- ner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred at the	ne time, date my opinion,	end place, deeth occur	and due to the rred et the time,	cause(s) and ma date end plece, a	nner as stand due to	ated. the cause(s)
ompletely filled Medical Ce	29b. Signature and	title of certifier				29c. Lie	cense numb	per		29d. Date signed	Month, L	Day, Year)
1	▶ S.	Pagur	ap	no		-	53			11/20	120	×00.
X	30. Name and address		ompleted cause of	f death (Iter	m 23a) (Type, I	Print) F	tella	s.Ro	mo	alox wp	1- 7	
State egistrar	31. Date filed (Mont	n, Day, Year) NOV 2 2 20	32. Regi	strar's Signa	ature	ho	2.11.1					

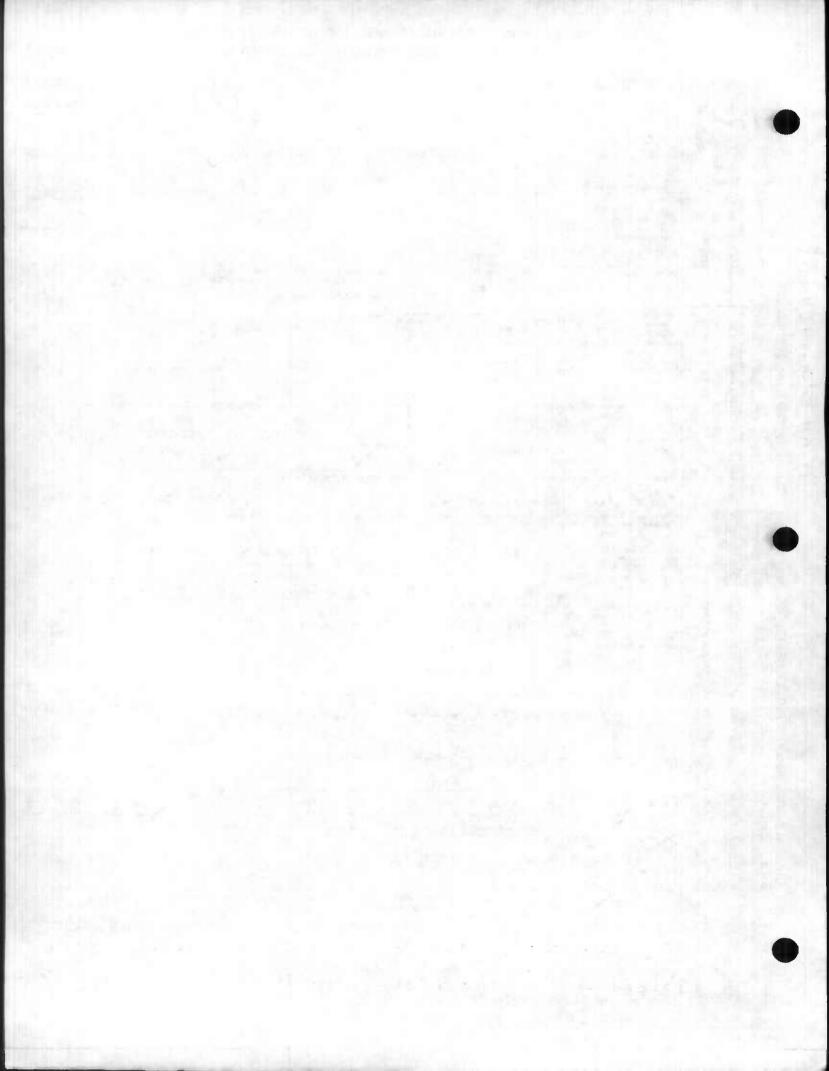


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	1 Decedestic Name (First Atlatic)	and h	Cei	rtificate of	Death		g. No.	2 Time of Death	
Physician	Decedent's Neme (First, Middle, Li					2. Dete of Death Month	Day Year	3. Tima of Death	
/Medical	MARY STACHAL				th City Town as I	Vov Emb	1		
Examiner	4e Facility Name (If not institution, gir			1.10	4b. City, Town, or Lo		4c. County of Death		
-		MERCY	on food birdhalous	If Under 1 Yeer	BALTIMO	8. Dete of Birth	N/A	-lane (State on Femilia)	
Funeral Director		I∏M 25₹F	yrs. lest birthdey) 75 Yrs.	Months Days		(Month, Day, 1/9/2.	Year) Cou	place (Stete or Foreign intry)	
Man Man	10a. Stete 10b. County		. City, Town or Lo	cation			10d. Inside City Limits		
r the Mary r 28a-f sh motified a	MD N	/A	BALTI	MORE				1. Yes 2 No	
5 0 A O	10e. Street and Number 2515 FOSTER	AVE.		10f. Zip Code 21	224	10	intry?		
020 vurs shar death v st, or thems 23s Examiner must by Furneral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		Wes Decedent of I I Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispenic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Bleck, White Specify: WH		
1 21215-0020 ed within 72 hours at yojene. wer than "natural", or ne than "natural", or it, the Medical Exam Completed by I	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12)		(Give	dent's Usuel Occu kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Business/li UNIVERSIT		
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Maryland 62 should be file it, and Mental Hy 7 is marked oth treumetic event	17. Father's Neme (First, Middle, Last ANTHONY STACI				18. Mother's Name	MILWIC			
Show and M	19e. Informent's Neme/Relationship	Type, Print)	19b. Meilir	ng Address (Stree	t end Number or Run	al Route Number,	City or Town, Stete, Z.	ip Code)	
- Sant	MR. WILLIAM BA				AVE. BA	LTO.,	MD.		
more	20a. Method of Disposition 1 Method of Disposition 1 December 2 Cremation 3 E 4 Donation 5 Other (Speci	Domoval from State		matory or other pla	CEME. 1	2000	BALTO.,		
Baltimore permit. Pages 1 i Department of He important: If then sny Injury or othe	21. Signeture of Funeral Service Lice		K	aczorow	SKI FUNE	ERAL HO	ME P.A.		
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Vital Re- sician: The lev certificate has irector, page 2 Be Comp	25. Wes case referred to medical				26. Place of Deal	h (Check only on	e)		
of ships at d	examiner? 1 Yes 22 No 27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Dey Yea	2 ER/Outpatier 28b. Time of fnjury	28c. Inju		ome 5 Reside 28d. Describe ho	onca 6 Sther (Spec ow injury occurred	ity) HOSPICE	
Division (To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		At home, farm, str pecify)	eet, fectory, offica		28f. Location (St City or Town	reet end Number or Ru n, Stete)	ral Route Number,	
• Hospit 124 hour • Funeral detely fill		nysician: To the best of my miner: On the basis of exam end menner steted.							
To the comp	29b. Signeture end title of certifier	IX	0	29c. Licen	se number		9d. Dete signed (Month		
1	Joseph D. 1	Volara	ngelo	M.D.	D0731	6	10V-14-	2000	
OR	JOSEPH D.	completed cause of deeth ((Item 23a) (Type,	Print)	P. 301.	ST. PAUL	- PLACE L	BALTIMONS	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrer's S							

ORIGINAL

many Stacharowski

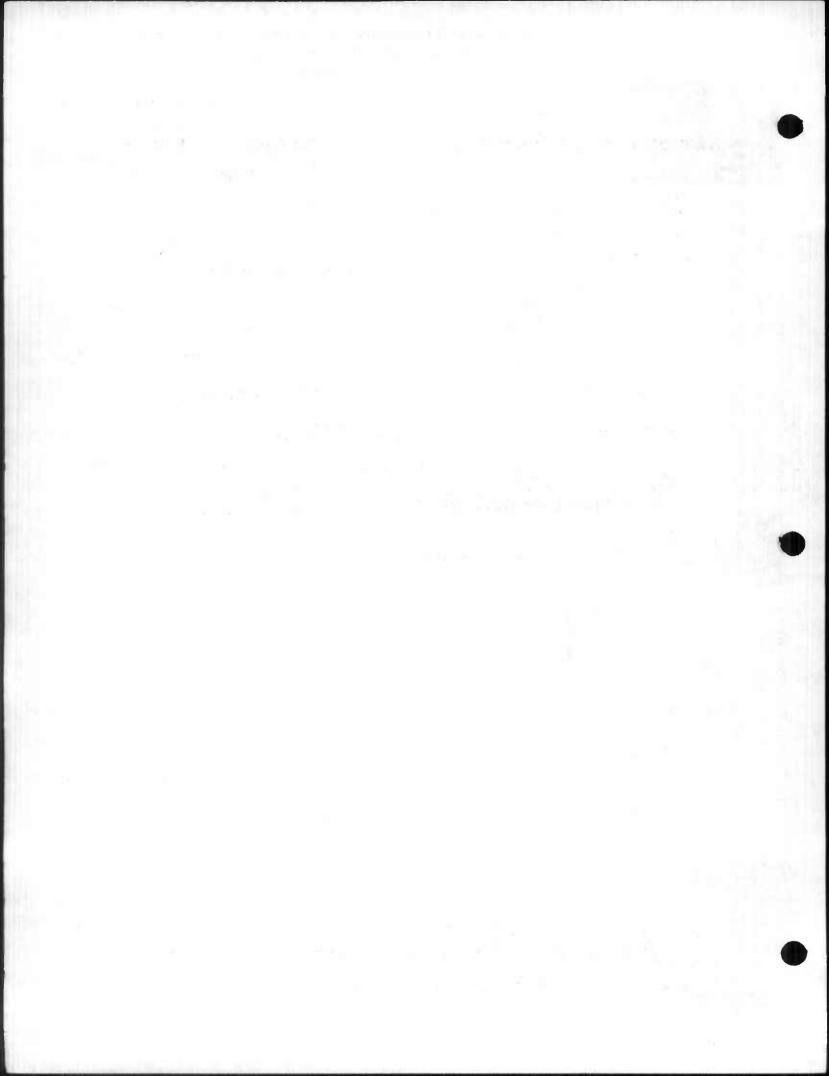


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of Maryland / Department of Health and Mental Hygiene	0.0	37

		State of	Maryland	Department of Certificate of	Health and Mental H	ygiene 00 37048			
Physic /Medi	cal	Decedent's Neme (First, Middle, Last) Harold Snider 4e. Fecility Name (If not institution, give street and num	ahari		2. Dete of I	Deeth 3. Time of Death at 17, 2000 eer a 3:40am			
Funeral Director	ner	VA Medical Center, Fort Howard 5. Sociel Sacurity Number 6. Sex 1 M 2 F		birthday) If Undar 1 Yea Yrs. Months Days	Fort Howard If Undar 24 Hrs. 8. Date of B	Baltimore 9. Birthpleca (State or Foreign Country)			
the Maryland 28a-f show	Director	Usuel Residence of Decedent 10e. Stete 10b. County MD N/A 10e. Street end Number	10c. City, T	own or Location Baltimore 101. Zip Code	2	10d. Inside City Limits 1 √ Yas 2 □ No 10g. Citizen of Whet Country?			
11215-0020 within 72 hours after death with the Maryland ane than "natural", or Home 23a or 28a-1 show he Medical Exemines must be coulded at	Funeral Dir	305 S. Gilmore Street	dent Ever in U,S.	2122 13. Was Decedent of If Yas, specify Cul	Hispenic Origin? (Specify Yas or Noan, Maxican, Puerto Rican, etc.)	USA			
21215-0020 d within 72 hours after dea jiane. r than "natural", or items the Medical Examiner in	Completed by	3 Widowed 4 □ Divorcad If Yes, Giv. Year or De 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1	ites:	6e. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin		Specify: Black 16b. Kind of Business/Industry			
yland 21215-C vuld be filed within 72 h Mental Hygiene. Irked other than "naturatic event, me Medical	To Be Com	11th N/A 17. Fether's Name (First, Middle, Last) Ernest Snider		Laborer	18. Mother's Neme (First, Middle Lorraine_Sand				
Battimore, Maryland 2121 permit. Peges 1 and 2 should be filed within Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, in the Menta.		19a. Informent's Name/Relationship (Type, Print) Carolyn Snider 20e. Method of Disposition	20b. Plac	19b. Mailing Address (Street 305 S. Gilm 305 S. Gilm 305 S. Gilm 305 S. Gilm	nore St Md 21223 Dete	iber, City or Town, State, Zip Code) 20c. Location - City or Town, State			
Baltimor pemit. Peges Depertment of infrontant: if its any injury or o		1 Buriel 2 Cremation 3 Removel from S 4 Donetion 5 Other (Specify) 21. Symatup of Funaral Service Licanuse 23. Pair 1. Enter the discusse, dr complications that completely one cause on each poor.	Garr	ison Forest	Cem 11/24/0	gwingsMills, Md			
Physician /Medicai Examiner		Immediete Cause (Final	of the La		ing, such as cardiac or respiratory	arrest, Approximate Intarval Between Onset end Deeth			
760, te be executed ysiclan and te buriel-trensit	cal Examiner								
Box 687 ath certificete ttending physic use es the	Physiclan/Medic	thet initieted events resulting in deeth) Lest	Due to (or es	e consequence of):					
ds, P.O. lires that the de signed by the ed be detached if	by	Pert II. Other eignificent conditions contributing to de	ath but not resultin	g in the underlying ceuse g		d tobacco use contribute to the cause of death Yes 2 No 3 Probably 4 Unknow			
I Record The law requireste has been signed and page 2 should	Completed	Hypertension			per	as en eutopsy formed? 24b. Wera autopsy findings available prior to completion of cause of deeth? 1 □ Yes 2 ☒ No			
of Vita hysician: his carificani	To Be			b. Time of 28c. Injury Wo		y one) sidence 6 □Other (Specify) e how injury occurred			
Division c spital or Attending P nours eiter death. neral Director: Affer t y filled in by the funera	al Certification:	3 Suicida 4 Homlcide 6 Could not be determined 28e. Plece buildin 29a. Certifier 1 X Certifying Physician: To the t	pest of my knowled	, ferm, street, fectory, office	28f. Location City or T	on (Street end Number or Rural Route Number, Town, Stete)			
Div To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in	Medical	(Check only one) 2 Medical Examinar: On the be end menn 29b. Signature and titla of certifier	sls of examinetion	and/or Investigation, In my	opinion, deeth occurred at the time isa number	e, date end plece, and due to the ceuse(s) 29d. Deta signad (Month, Day, Year)			
CX:4		30. Name and eddress of parson who completed cause Aurora C. Tan, MD 9600 North R	,		21052	November 17, 2000			
Sta Registr		31. Date filed (Month, Day, Year) NOV 2 2 2000	gistrar's Signature	5 Sparks					

DHMH 16 Ray 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** :05 November 20, 2000 cation of Death 4c. County of Death Lynn Annette Sweets /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) Examiner Baltimore City Stella Maris at Mercy Hospital Baltimore If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2 XF Days Hours Yrs. 220-64-4590 42 Director October 4,1958 Maryland Usual Rasidence of Decedant with the Maryland 10c. City, Town or Location
Baltimore 10a, Stata 10b. County Baltimore City 10d. Inside City Limits 28a-f ahon the Medical Examiner must be notified at MD Yes 2 No Director 10e Street and Number 10f. Zin Code 10g. Citizan of What Country? 6 21223 United States 234 2143 West Fayette Street Funeral filed within 72 hours after death 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. XXNevar Married 2 Married 8 Maryland 21215-0020 Specify Black 1 ☐ Yas 2 XNo Specify py 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) 7th Collega (1-4or 5+) homemaker OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pagas 1 and 2 should be in ment of Health and Mental ant: If Item 27 is marked or Henrietta Archer Haidi Hayes 19a. Informant'a Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 820 Clintwood Ct., Baltimore, MD 21225 Kiana Tillman- daughter Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Department of Important: If its any injury or o Burial 2 Cramation 3 Ramoval from Stata MT. ZION CEMETERY 11-27-00 4 ☐ Donation 5 ☐ Othar (Specify) LANSDOWNE, MARY LOND 21. Signature of Funeral Service Lice Joseph H. Brown JR Funeral Home 2140 N. Fulton Avenue, Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Interval Batween Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical **Examiner** Physician/Medical Examine Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disease or Injury that initiated evants rasulting In death) Last The law requires that the death certificate be asscul Box 68760. Dua to (or as a consequence of) usa as the P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dinknown of Vital Records. þ 24b. Wera autopsy findings available prior to completion of causa of death? page 2 should Be Completed 24a. Was an autopsy Aftar this certificata has 2000 1 ☐ Yas 2 ☐ No 1 ☐ Yas al or Attending Physician: To safter death.

I Director: After this certificat od in by the funeral director, pa 25. Was casa rafarred to medical 26. Placa of Death (Check only one STE //A MARIS Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 | Nursing Homa 5 | Rasidance 6 Othar (Specify) + 63pics 1 Yas 2 No Certification: To 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of Division 1 Natural
2 Accident 5 Pending 1 Yas 2 No invastigation 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number.
City or Town, Stata) filled in by 4 Homlcide To the Rospital within 24 hours a To the Funeral C ← Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

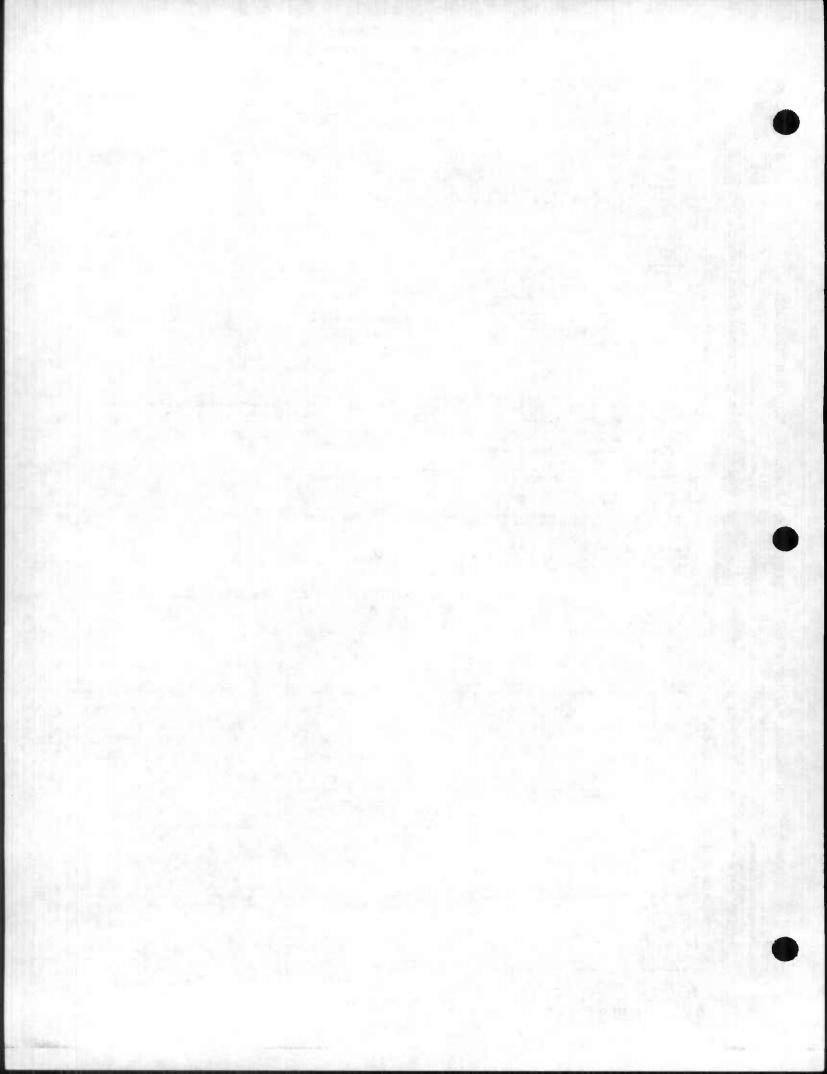
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medica 29a. Cartifier 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifie 29c. Licansa number NOV. 21, 2000 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) BAHIMORE RISEDERG AUID 31. Data filed (Month, Day, Year) 32. Pegistrar's Signatura

DHMH 16 Rev 6/95

State

Registrar

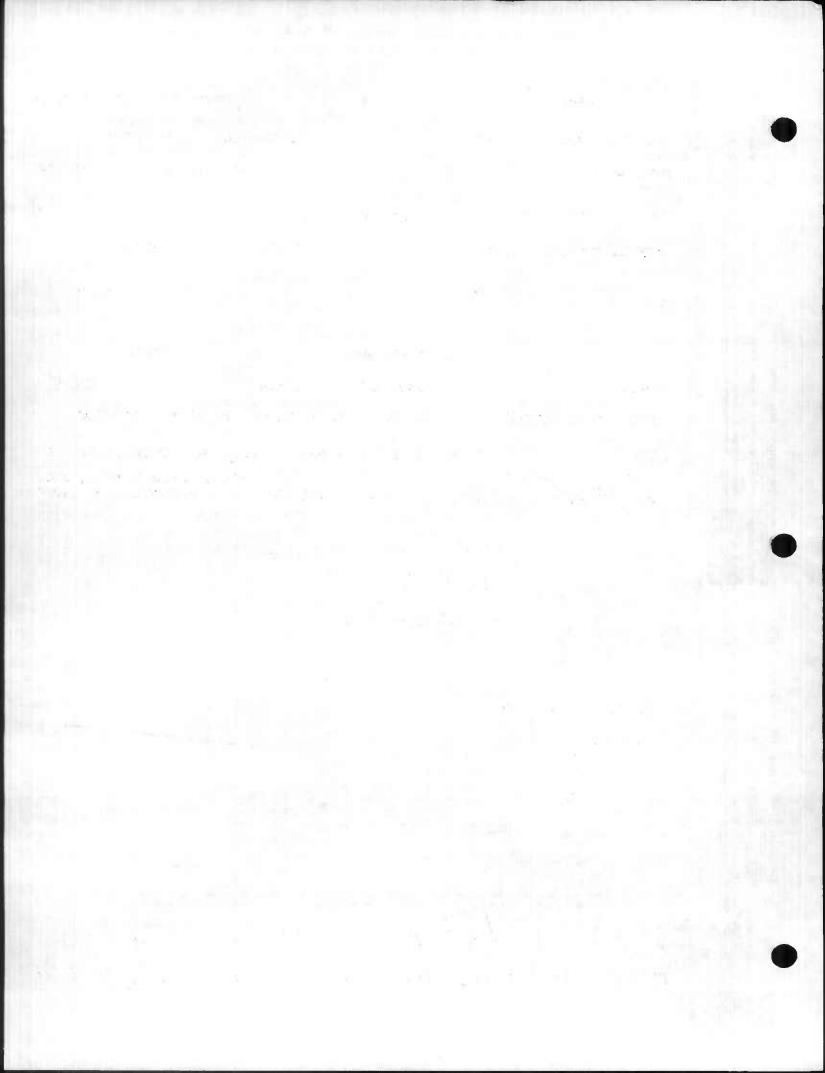
NOV 2 2 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 3 7 0 5 0

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth NOVEMBER 19, 2000 **Physician** 8:00 AM SNYDER MARY /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner BALTTMORE LUTHERVILLE BRIGHTWOOD GENESIS NURSING HOME Birthplece (Stete or Foreign Country) If Under 1 Year If Under 24 Hrs. 5 Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) NOV . 3, 1916 **Funeral** Months 1□ M 257 F Deys Hours CANADA 84 Director 286-01-5078 Usuel Residence of Decedent the Menylend 10a Stete 10d. Inside City Limits 10b County 10c. City. Town or Location ehow 7 le merked other than "natural", or items 23a or 28a-f ebor traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE BALTIMORE MD Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21208 409 OLD CROSSING DRIVE U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien. Bleck. White, etc. nit. Peges 1 end 2 should be filed within 72 hours efter (actinent of Health and Mental Hygiene. ortant: If item 27 le marked other than "natural", or ite injury or other traumate event, pre Mental Earn he 1 ☐ Never Merried 2 ☐ Merried WHITE Maryland 21215-0020 1 Tyes 2 No Specify: Specify: by 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18 Mother's Neme (First Middle Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be SPIRIT CHERTKOFF SONIA BORIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 409 OLD CROSSING DRIVE - BALTIMORE, MD 21208 MICHAEL SNYDER / SON Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriei 2 ☐ Cremetion 3 ☐ Removel from State RANDALLSTOWN, MD permit. Pege Department of Important: If BETH EL MEMORIAL PARK 11/21/00 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature Funeral Service Lic 22. Name end Address of Fecility eny In SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Mes 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Cardionalmonar tmmediete Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Examiner hydration physician end the bunel-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. the deeth certificate be Physician/Medical Due to (or es e consequence of): 89 esn Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? P.O. Wilorder. 1 Yes 2 No 3 Probably 4 Unknown signed by hi mols Division of Vital Records, þ 8 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? Derression. Completed 24e. Wes an eutopsy page 2 has De men In 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: director 25. Wes cese referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1. Naturei efter deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Huneral C 29a. Certifier 1 🚰 Certifying Phyetctan: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. Medical (Check only one) 2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and eddress of person, who completed cause of death (Item 23e) (Type, Print) Court Nd, Raffinore; no 21228 1172n 70 4000 31. Date filed (Month, Dey, Year) NOV 2 2 2000 32. Registrer's Signeture State Registrar



Physician	
/Medical	
Examiner	

Marie Catherine Smith

2. Date of Death November 18, 2000

3. Time of Death 11:15 PM

4a Facility Name (If not institution, give street and number) Stella Maris

4b. City, Town, or Location of Death Timonium

4c. County of Death Baltimore

Funeral Director

the Maryland

with

deeth

72 hours after

Physician

/Medical

Examiner

attending physician and for use as the burial-trensit

signed by t

ueec

has page

certificata Physician:

After this funeral di

Diractor:

Funeral D

Hospital or Attending

The law requires that the death certificate be executed

Box 68760

P.0.

Division of Vital Records,

SMITH

MARIE

Physician/Medical Examiner

Š

Completed

Be

10

Certification:

edical

2000

WOVEMBER 18,

10a State MD Director 10a, Street and Number 1701 Commons Ct.

7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic avent, the Hedical Examiner must be notified at Funeral by Completed tel Hygiene. permit. Pages 1 and 2 should be filt.
Department of Health and Mentel Hy
Important: If Itam 27 Ia marked oth
any fnjury or other traumatic avent

5. Social Security Number 212-05-0156 Usual Residence of Decedent

1 M 2 F

7. Age (In yrs. last birthday) 90

If Under 24 Hrs If Under 1 Year Days Hours

Date of Birth Month, Day, Year) 10/4/1910

9. Birthplace (State or Foreign Mary Land

10d. Inside City Limits

1 Yes 2™No

10b. County

Baltimore

10c. City, Town or Location Rosedale

Months

10f. Zip Code 21237 10g. Citizen of What Country?

U.S.A.

11 Marital Status

1 Never Married 2 Married 3€Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XNo Specify:

14. Race - American Indian, Black, White, etc. Specify: White

16a. Decedent's Usual Occupation

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Homemaker

Own Home

17. Father's Name (First, Middle, Last) John Paptistella

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

18. Mother's Name (First, Middle, Maiden Sumeme) Rose Simon

19a. Informant's Name/Reletionship (Type, Print) Barbara Cherewko/Daughter

20b. Placa of Disposition (Name of cemetery, crematory or other place)

1701 Commons Ct. Baltimore, Maryland 21237 20c. Location - City or Town, State

20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Parkwood Cemetery

11/22/00 Baltimore, Maryland

21. Signature of Fundral Service Licensee

22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

23a. Part. Enter-the disease, or complimations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting In deeth)

RECTAL CANCER

Due to (or as a consequence of)

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

Due to (or as a consequence of):

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause ot death?

Approximate Interval Between Onset end Death

1 ☐ Yes 2 ☒ No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No

27. Menner of Death 5 Pending investigation 1 Neturel 2 Accident

6 Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

TIMONIUM, MD 21093

26. Place of Deeth (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

3 Suicide

4 Homicide

110 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number D43725 29d. Date signed (Month, Day, Year)

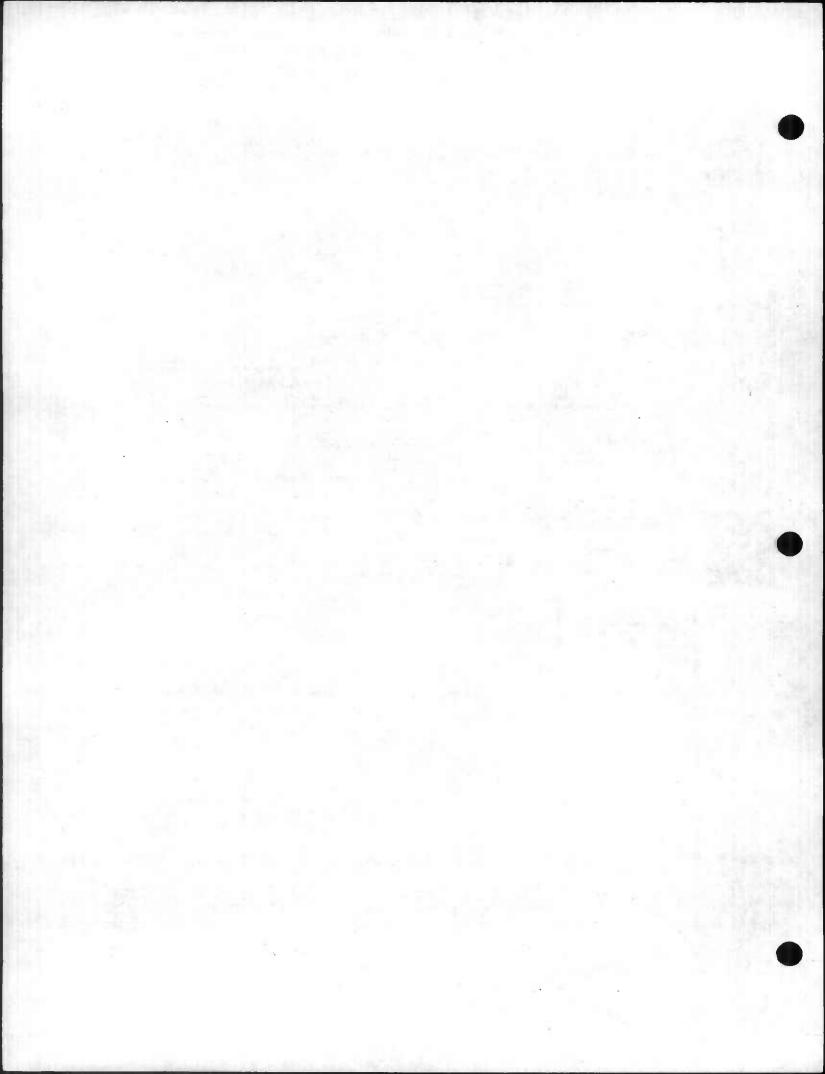
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

NOV 2 2 2000

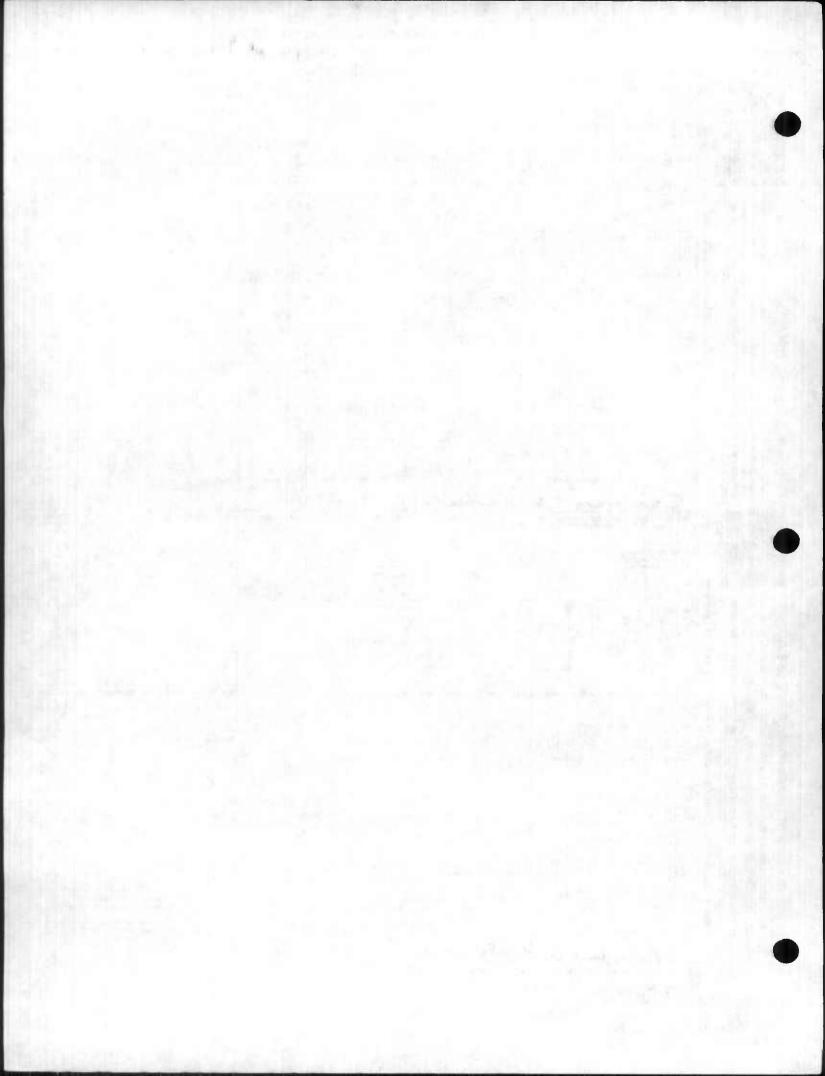
2300 DULANEY VALLEY RD. 32. Registrar's Signature

Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, 7052

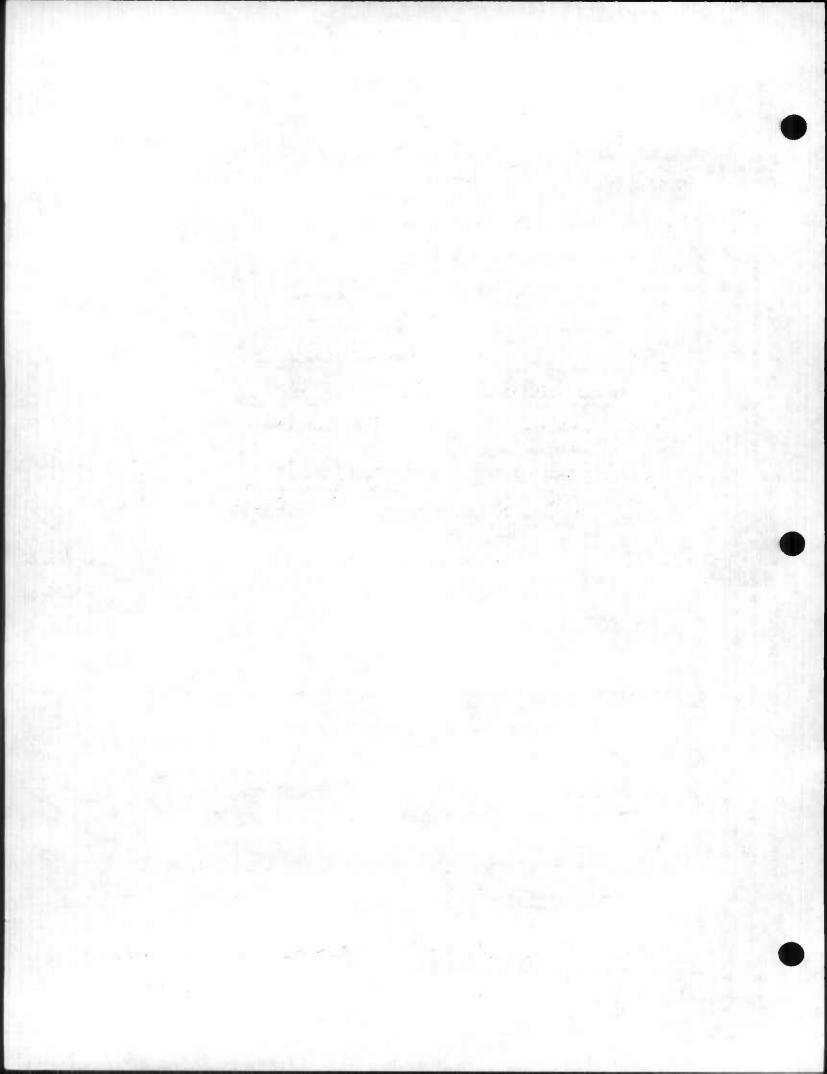
## AIRNED TYPES# 23 & 27 per ME 0792 022701 SS **Certificate of Death** 1.0 personal formation of the personal formation					
Michael Bradley Tillson Facility Name (If not hatfolitops, pive street and number) HOLY CROSS HOSPITAL Social Social Social Social Number 123-59-8820 Library Residence of Decoders 100, State 100, County 100, Chy, Town of Location 100, State 100, County 100, Chy, Town of Location 100, State 100, County 100, State 100, State 100, County 100, State 100, State 100, County 100, State 100, State 100, State 100, State 110, State 110, State 111, State 212, State 212	Death				
Found The County Name (if not institution, give street and number) The County of Deeth The County of Dee	PM				
Social Security Number Social Security Num					
Usual Residence of Decederal 10a. Steal 10b. County 10c. Chy. Town or Location 10 Steal 10b. Steal 10b. County 10c. Steal 10b. County 10c. Steal 10b. County 10c. Chy. Town or Location 10c. Steal 10b. County 10c. Steal 10b. Steal 10b. County 10c. Steal 10b. Steal 10b. County 10c. Steal 10b. Steal					
Usual Residence of Decedent 10c. Street and Number 10c. Clly. Town or Location 10d. Inside C 1□ Yes 10d. Toy Code 1□ Yes 10d. Street and Number 10d. Street and Number 10d. Street and Number Country? 10d. Toy Code 11d. Markat Sterus 11	Foraign				
MD Howard Columbia 10					
1. Marriel Stetus 1.2 Was Decedent Evar in U.S. Amed Forces 1.2 Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - Amarican Indian. Black, White, etc. 5pecify: Cuben, Neaccan, Peerfor Rican, etc.) 1.4 Race - Amarican Indian. Black, White, etc. 5pecify: White 1.5 Decedent 1.5 Decede	y Limits				
1.1 Martiel Stetus 1.2 Was Decedent Ever in U.S. Amed Forces 1.2 Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Reac - American Indian. Black, White, etc. 5/10 Period of Martiel Stetus 1.2 Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Reac - American Indian. Black, White, etc. 5/10 Period of Working of	2 X) No				
11. Marital Status 12. Was Decedent Evar in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify: White 12. Specify: White 12. Specify: White 12. Specify: White 13. Was Decedent of Hispanic Origin? (Specify: White, etc. 12. Specify: White 13. Was Decedent of Hispanic Origin? (Specify: White, etc. 12. Specify: White 13. Was Decedent of Hispanic Origin? (Specify: White, etc. 12. Specify: White 13. Was Decedent of Hispanic Origin? (Specify: White 13. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin?) (Specify: Yes or No. Was Decedent of Hispanic Origin.) (Specify: Yes or No. Was Decedent of Hispanic Origin.) (Specify: Yes or No. Was Decedent of Hispanic Origin.) (Specify: Yes or No. Was Decedent of Hispanic Origin.) (Specify: Yes or No. Was Decedent of Hispanic Origin.) (Specify: Yes or No. Was Decedent of Hispanic Origin.) (Specify: Yes or No. Was Decedent of No. Was Dec					
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30. Nama and addrass of person who completed causa at daath (Item 23a) (Type, Print)	Xr.				
THE DONE MIKING 111 Penn Street, Baltimore, Maryland 21201					
State State Registrar \$1. Dete filed (Month, Day, Year) 32. Registrer's Signetura					



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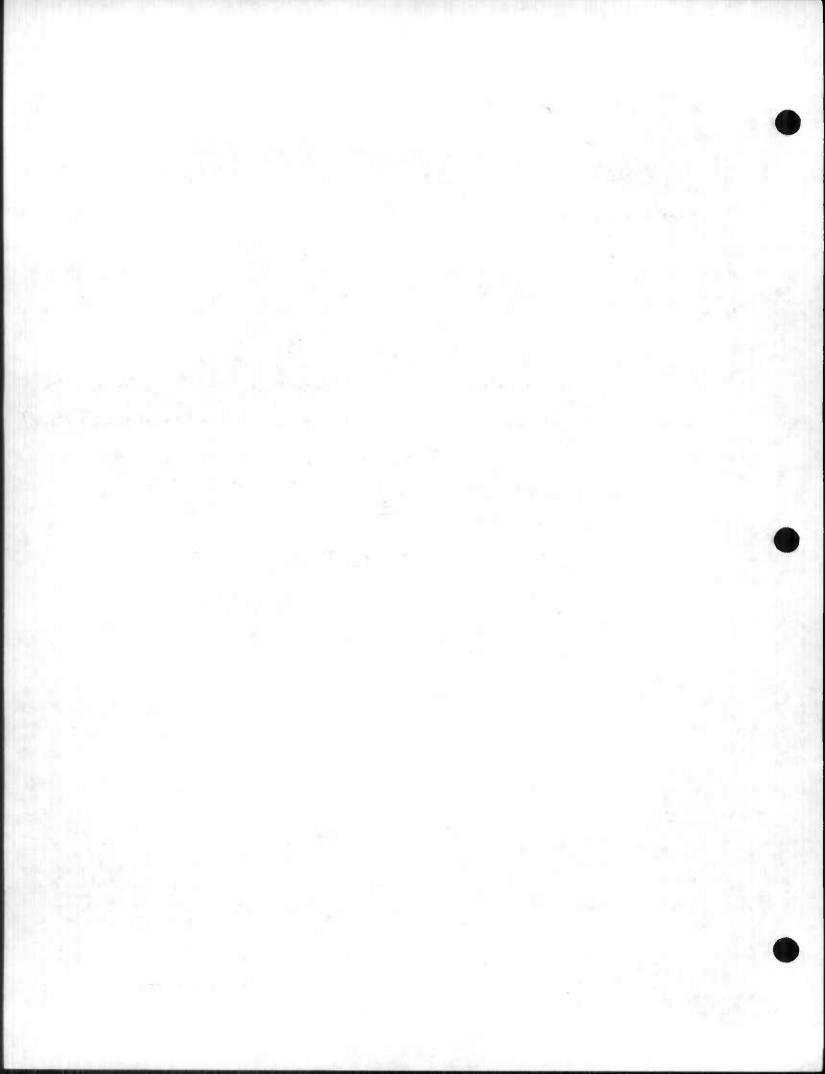


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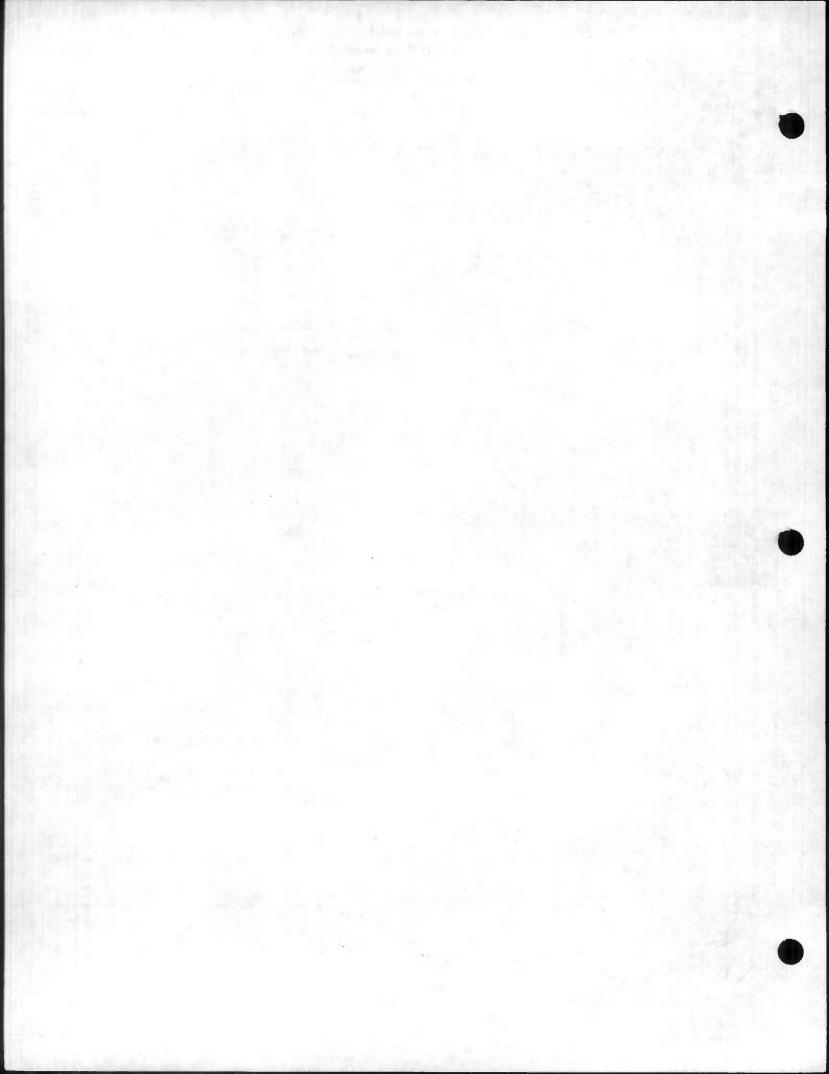
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU AMEND FIEM: 13 FER F.H. G789 11-22-00 WR. amend item 12 per fh G789 11/27/00 yf Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Day **Physician** 6:32 PM 20 2000 11 AUSTIN,,WARE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) Examiner LAUREL PRINCE GEORGES LAUREL REGIONAL HOSPITAL if Under 1 Yeer If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Deta of Birth (Month, Day, Year) **Funeral** X□M 2□F Min Months Days Hours **GEÓRGIA** 58 9,14,1942 Director 257-66-3145 Usuel Residence of Deceden 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location hems 23s or 28s-f shoulder at the maint be notified at 1 X Yes 2 □ No MD PGCO LAUREL Directo 10a. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 20707-USA 6914 MAYFAIR TERRACE Funeral 12. Was Decedant Ever in U.S. Armed Forces? 1 DYas 90 He ff Yes, Give Year or Detas: 1960-1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status the Medical Examinar Bleck, White, etc. hours after 1 Navar Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or Yes 2 No Specify: No Specify: BLACK þ Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 Hygiene. Etementery/Secondery (0-12) College (1-4or 5+) CARPET MILL SUPERVISOR 11 parmit. Pages 1 and 2 should be the Department of Health and Mental Hyy Important: If them 27 is marked othe any injury or other traumatic avant, pages. 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) 88 HENRIETTA WARE UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 6914 MAYFAIR TERRACE LAUREL MD 20707 DALE WARE /SON 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 Cremation 3 Removal from Stata
4 Donetlon 5 Other (Specify) 11/26/2000 ROME, GA **EASTVIEW CEMETERY** 21. Signetype of Funerel Service Licensee 22. Neme end Address of Fecility MARSHALL W. JONES JR. FUNERAL HOME P.A. Le a ma con 4101 Edmondson Avenue Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that ceums the deeth. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each ne. Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Acute Pulmonary Embolism Days Examiner Due to (or as e consequence of): Examine End Stage Renal Disease Years attending physician and for use as the burial-transit certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): The lew requires that the death ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yss 2 No 3 Probably 4 Unknown signed t by 24b. Ware autopsy findings evailable prior to completion of ceuse of deeth? 24a. Wes an autopsy performed? Completed peeu 188 page 2 1 ☐ Yes 2 No certificate 1 ☐ Yes 🎇 No Division of Vital Physician: 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: № Inpatiant 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) To this funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After t or Attending 5 Pending invastigation after death.

Director: After din by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Ptace of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) to the Hospica.
Within 24 hours after
to the Eurarial Dir 4 ☐ Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medicat Examiner: On the besis of examend menner steted. (Check only one) minetion and/or investigation, in my opinion, deeth occurred at the time, dete and pleca, and dua to the cause(s) 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

State Registrar

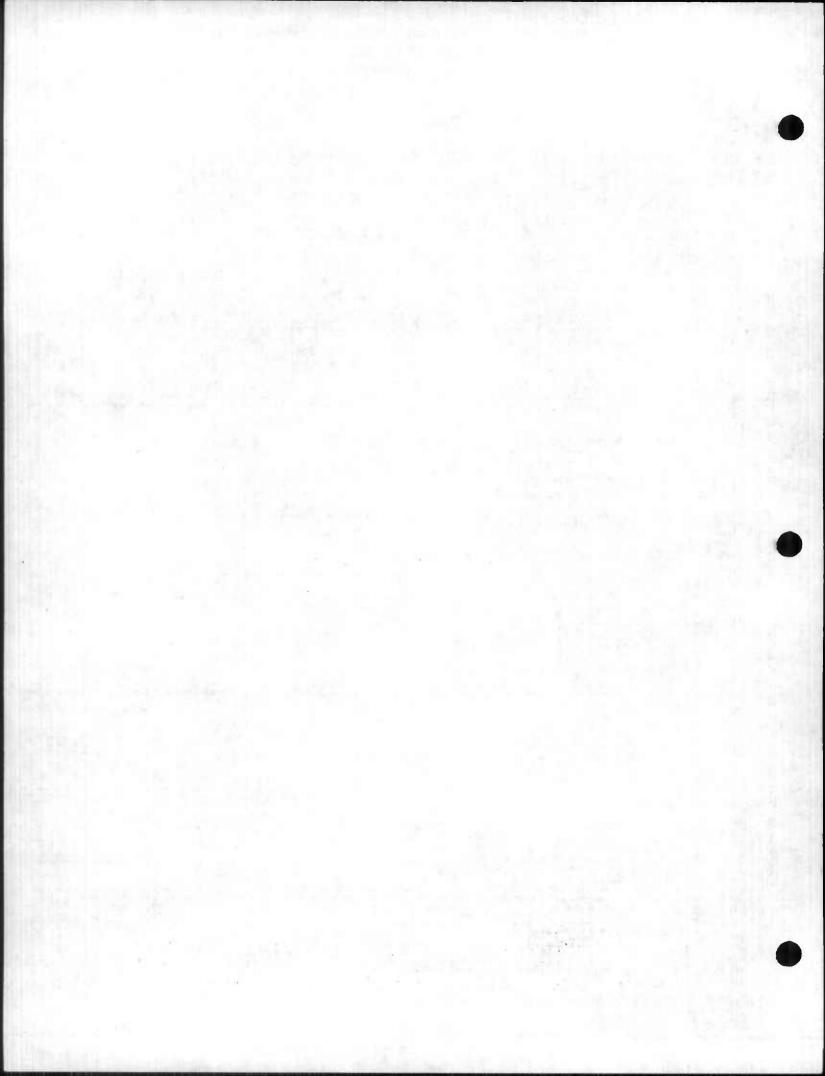
31. Date filed (Month, Day, Year)

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14333 LAYRELDOWIE 32. Registrer's Signature

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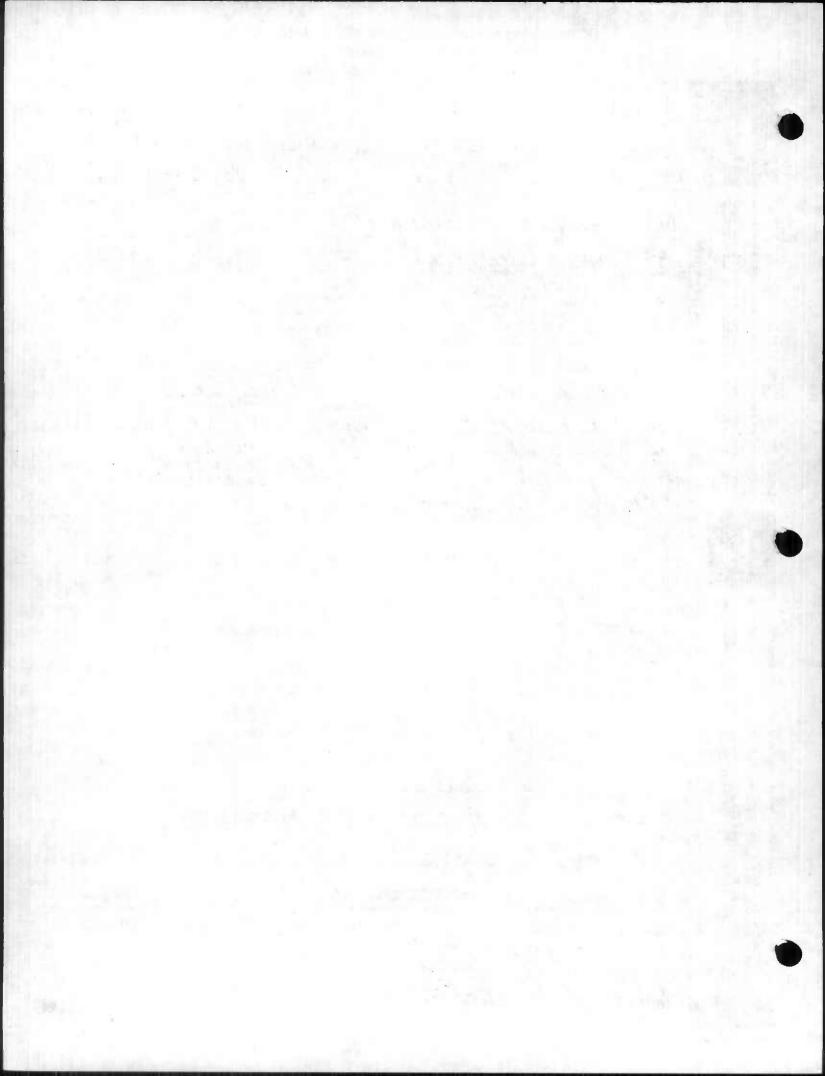
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death Month **Physician** GV /Medical 4e Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 5. Social Security Number side 0 8. Dete of Birth Month, Dey, H Under 1 Ves 9. Birthplace Country) 6. Sex 7. Age (In yrs. last birthdey) (Stete or Foreign **Funeral** Sex Months Deys Hours Yrs. Director the Maryland 10b. County 10e. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f above traumstic avant, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien. 11. Merital Stetus 12. Wes Decedent Ever in U.S. Bleck, White, etc. 1 ☐ Yes 2 X No 1 Never Merried 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 Specify by 3 Widowed 4 □ Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Hygiene. 18. Mother's Neme (First, Middle, Maiden Subjeme) 17. Fether's Neme (First, Middle, Last) . Pages 1 and 2 should be filk iment of Health and Mental Hy lant: If them 27 is marked oth jury or other traumatic avam Be 19e. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 285 NOV 21 Method of Disposition 20c. Location City or Town, Stele 1 Surial 2 Cremetion 3 Removel from Stele 4 Donation 5 Other (Specify) permit. Page Department of Important: If any Injury or once. vano Funeral 21. Signeture of Funeral Service Licental 22. Name and Address of Facility 23a. Perft. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, which es cardiac or respiretory errest, shock, or heart leilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examine ongest that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Las! Due to (or es e consequenca of): P.O. Box 68760 **Physician/Medicai** Due to (or es e consequence of): ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No signed b Division of Vital Records, by 24b. Were autopsy lindings svailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 s certificate has 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: 1□ Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 Inpatient 2 ER/Outpatient 3 DOA this luneral 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? After t Certification: To the Hospital or Attanding I within 24 hours after death.
To the Funeral Director: After 1 Waturel 5 Pending investigation 1 ☐ Yes 2 No filled in by the 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dele and plece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) end menner stated. edical completely (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

Registrar

DHMH 16 Rev 6/95

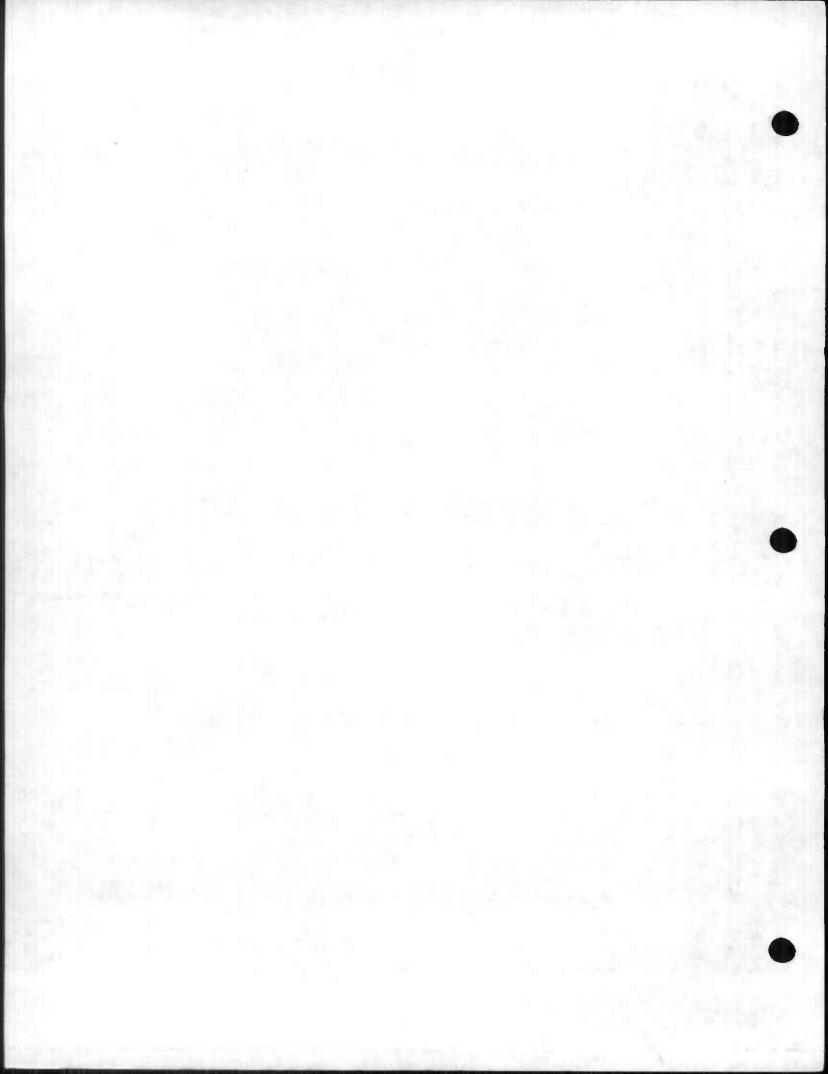
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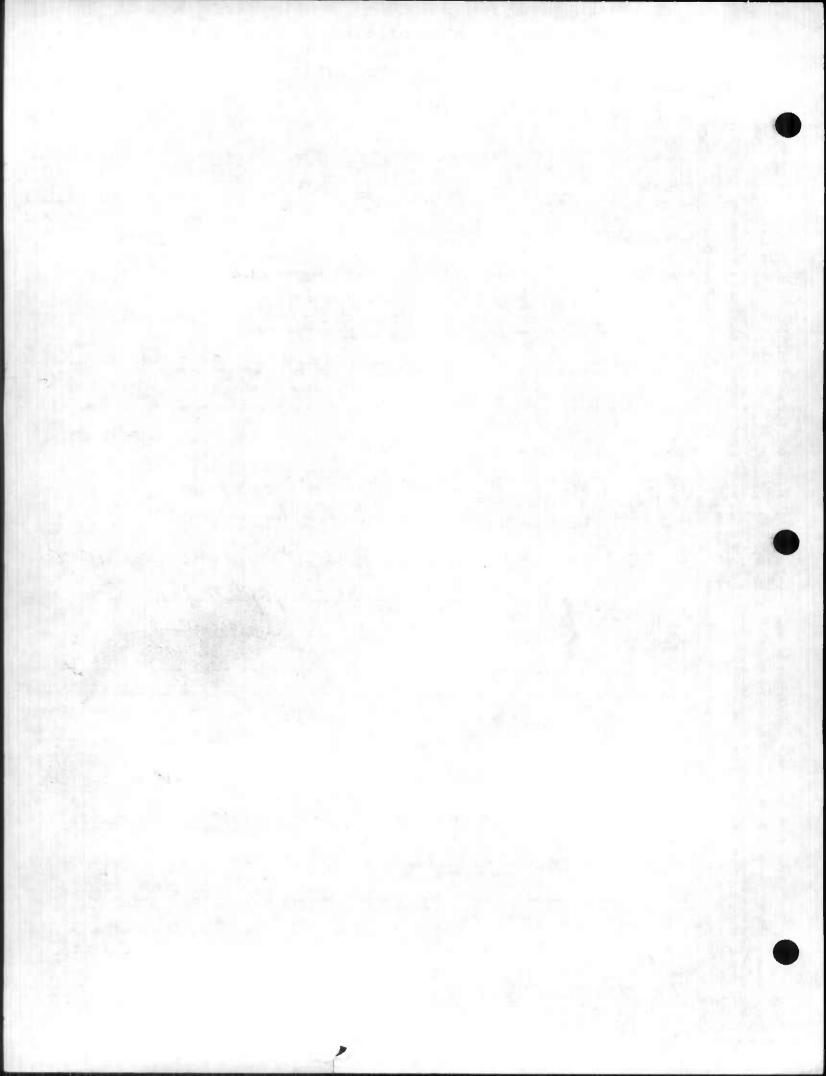
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Certificate of Death

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Examiner		Sex 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Deys		8. Dete of Birti	Baltin	nore 9. Birthplace (State or Foreign Country)
Director	214-20-9485	73	113.			06/09/	1927	MD
pu .	Usuel Residence of Decedent 10a. Stete 10b. County	10c City	, Town or Loc	eation				10d. Inside City Limit
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The Port	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
h w 1					21228		USA	A
or he mine	11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 Xyes 2 No If Yes, Give Yeer or Dates:		Ves Decedent of I Yes, specify Cub	Hispenic Origin? (S sen, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race Blace Specify	e - American Indien, sk, White, etc. White
hou and b	15. Decedent's 8		16a Deced	ent's Usuel Occu	nation		16h Kind of Bu	usiness/Industry
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Hospi 24 hour Funer tely fil	29a. Certifier (Check only one) Certifying F	hysician: To the best of my known iminer: On the basis of examiner and menner stated.						
To the within To the comple	29b. Signeture and title of certifier	1		29c. Licen	se number		29d. Date signe	d (Month, Day, Year)
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110	1 /char	a. Jy	1	31	140		11	20 00
50	30. Name and address of berson who	completed cause of deeth (Item	23e) (Type, I	724	+ Maio	len C	hoice	-20-00 LA.
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Signe	ture J.	Loone	21			



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State of Maryland / Department of Health and Mental Hygiene

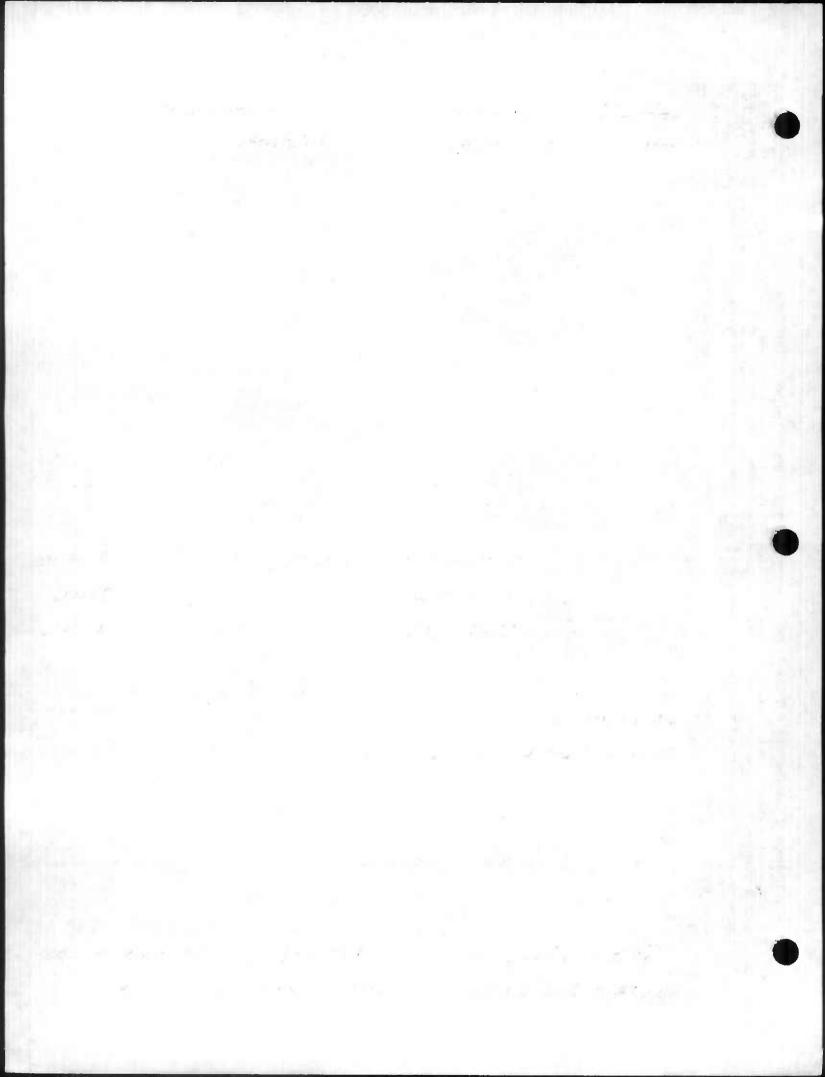
Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Year **Physician** CHARLES WIDERHAN 15:30 BW MONEMBER 12 5000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE HARBOR HOSPITAL CENTER N/A If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. 73 **Director** 216 20 4544 Jan. 1, Maryland Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2 No N/A Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Items 23s or 2853 Hollins Ferry Road 21230 U.S. Funeral filed within 72 hours after death 14. Raca - American Indian 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 17∑ Yes 2 □ No If Yes, Give Yeer or Detes: W.W. II 1 □ Never Married 2 □ Married Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: by White 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondery (0-12) College (1-4or 5+) Fire Fighter Baltimore City 8th other i 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental int: If Item 27 is marked or Bertha Prendergast Raymond Widerman 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2420 Zion Road Baltimore, Maryland 21227 Karen Cave Daughter Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete permit. Pages Department of Important: If Its eny Injury or o 1 Burial 2 □ Cremation 3 □ Removal from Stete 11/20/00 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Lice Gonce Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feiture. List only one cause on each line. Baltimore, Md. 21225 Intervel Between Onset and Death Physician Immediete Cause (Finet disease or condition resulting in death) /Medical CARDIOARESPIRATORY ARREST 1 minute Examiner Due to (or es a consequence of) Physician/Medical Examiner 20 DAYS AIUOHUJU9 The law requires that the death certificate be assecuted attending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): GASY I Box 68760. CANCER CUNE thet initiated events resulting in death) Lest Due to (or es e consequence of): signed by the at d be datached for 23b. Did tobacco use contribute to the cause of death? P.0. Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION þ Division of Vital Records. 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? Completed CORO HARY ARTERY DISEASE has 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificata The property of Attending Physicien: The property after death.

The property After this certificate of in by the funeral director, pa Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) exeminer? Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Netural Injury 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Ptaca of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital south of the Fullians 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and menner stated. Medical 29e. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) res 001 MOVEMBER 15 2000 HOSPITAL CENTER HARBOR JOSE CIANGRECO OMASILIUS 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Marcason

DHMH 16 Rev 6/95

Registrar

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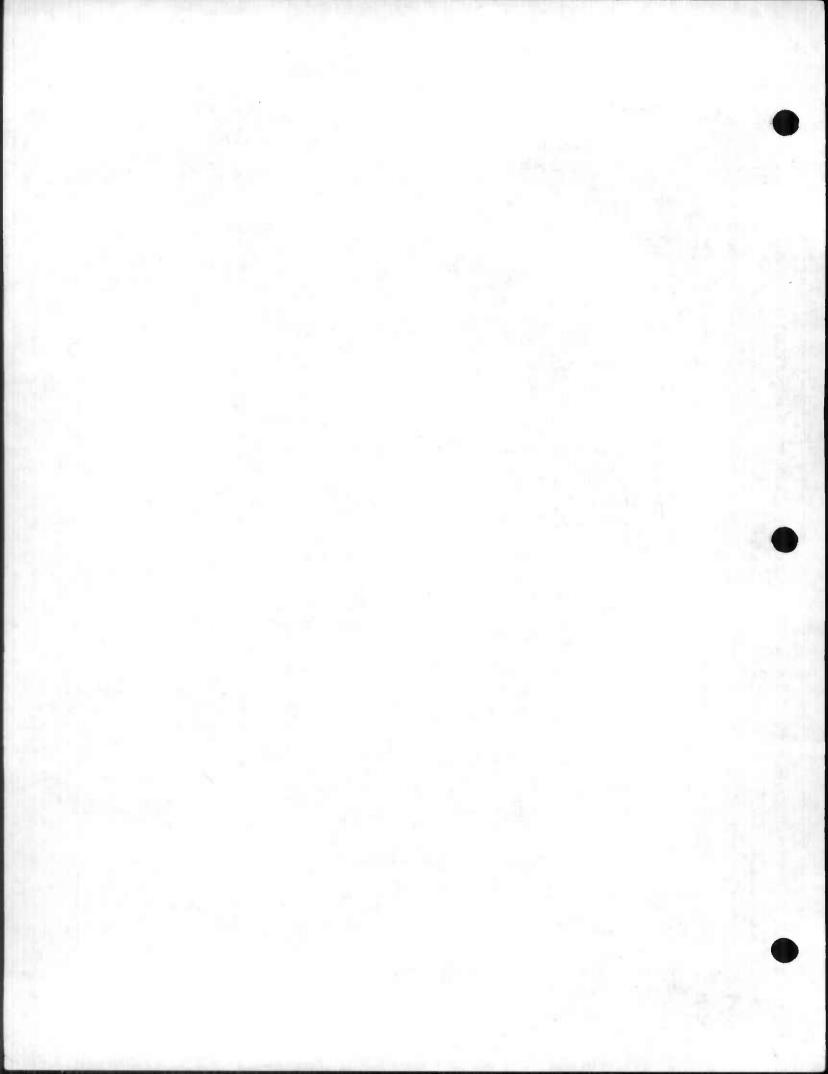
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 909 ovember 16,2000 MARGARET M. WILSON /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Baltmire Maryland General N/A If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Months 1□M 200 F Yrs 44 Director 216-68-4764 02-28-56 BALTO. Usuet Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits BALTIMORE 1 Yas 2 No MD N/A Director 288-1 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code ŏ U.S.A. 437 ORCHARD ST 21201 Funeral Wes Decedant of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indien, Black, Whita, atc. 1 ☐ Yas 2X No 11 Never Marriad 2 Married BLACK 1 Yas 2 No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced Year or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) DOMESTIC 10 HOUSEWIFE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Pages 1 and 2 should be next of Health and Mental LINCOLN SMITH LUCY WILSON 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) If Health I 3917 EDMONDSON AVE, BALTO. MD 21229 LUCY WILSON, MOTHER 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 □ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) WESTERN CEMETERY 1.1-25-00 BALTIMORE, MD 21. Signatura of Funeral Samoo Licor 22. Nama end Addrass of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO.MD 21207 complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, give the cause on each line. 23a. Part1. Enter the diseal shock, or heart failure. Approximate tritarval Batween Onsat and Deeth **Physician** . Acute Sickle Cell /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disaase or injury that initiated evants Box 68760, Due to (or es a consequence o that initieted evants resulting in death) Lest P.O. Pert II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by Records, 24b. Wara autopsy tindings availabla prior to complation of causa of daath? 24a. Was an autopsy performed? 12 Yas 1 Yas 2 No ongestion of Vital Physician: filled in by the funeral director, 25. Was case ratarred to medical examinar? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Home 5 Rasidence 6 Othar (Specify) After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28c. Injury at Work? Division or Attending 1 Natural 5 Panding invastigation after deeth. 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarmined 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida In the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura end titla of certifiar wani 30. Nama and addrass of person who completed causa of death (19m 23a) (Type, Print) 40 aryland m.O. 31. Data filed (Month, Day, Year) 32. Registrer's Signature

State Registrar

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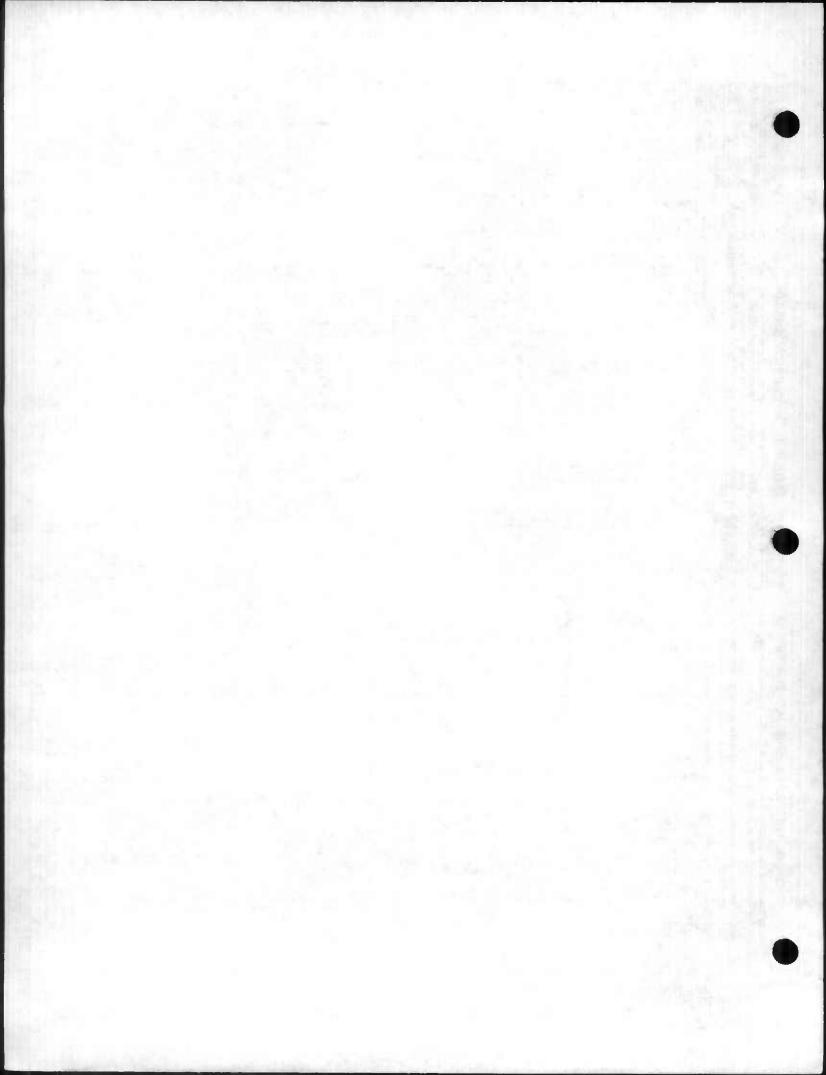


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eal ner	Ezra 4a Facility Neme (If not institution)	give street and numi	oer)	V	/ilsor	1 4b. City, Town, or	Novembe Location of Deat		000 v of Death	15:47
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	5. Social Security Number	6. Sex 7	Age (In yrs. last		der 1 Yeer	if Under 24 Hrs	8. Dete of Bi	rth Vanal		lace (State or Foreign
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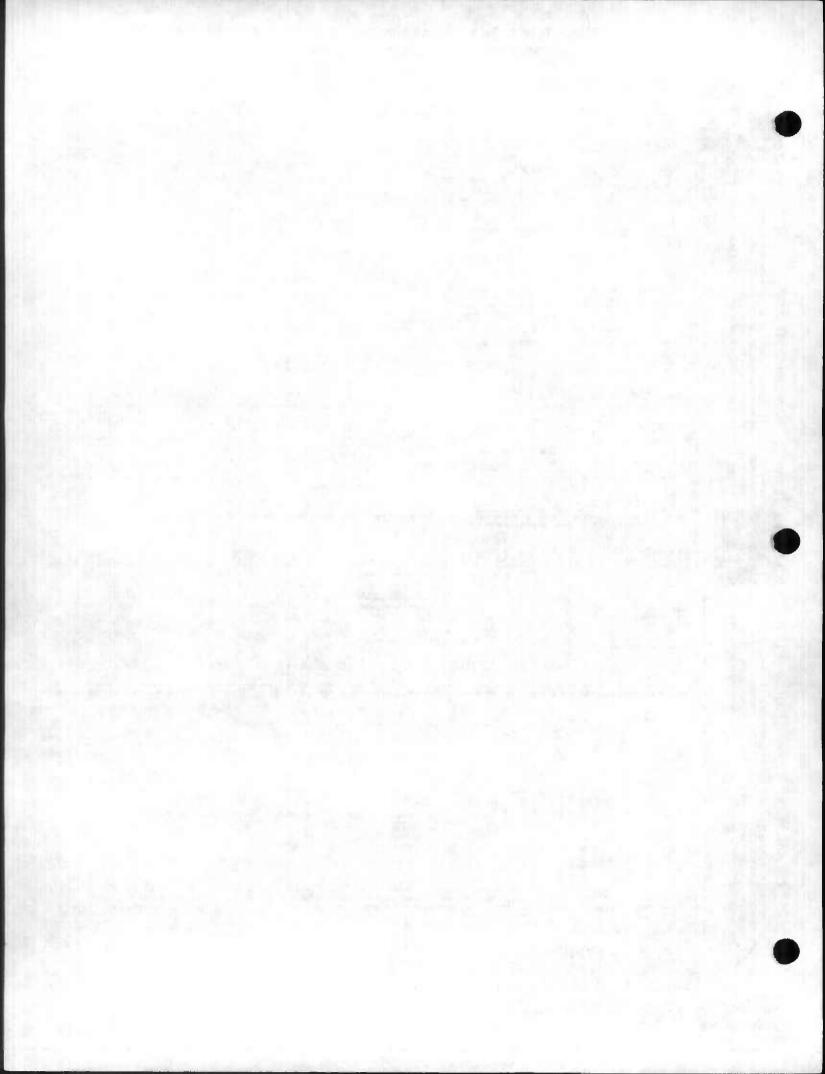
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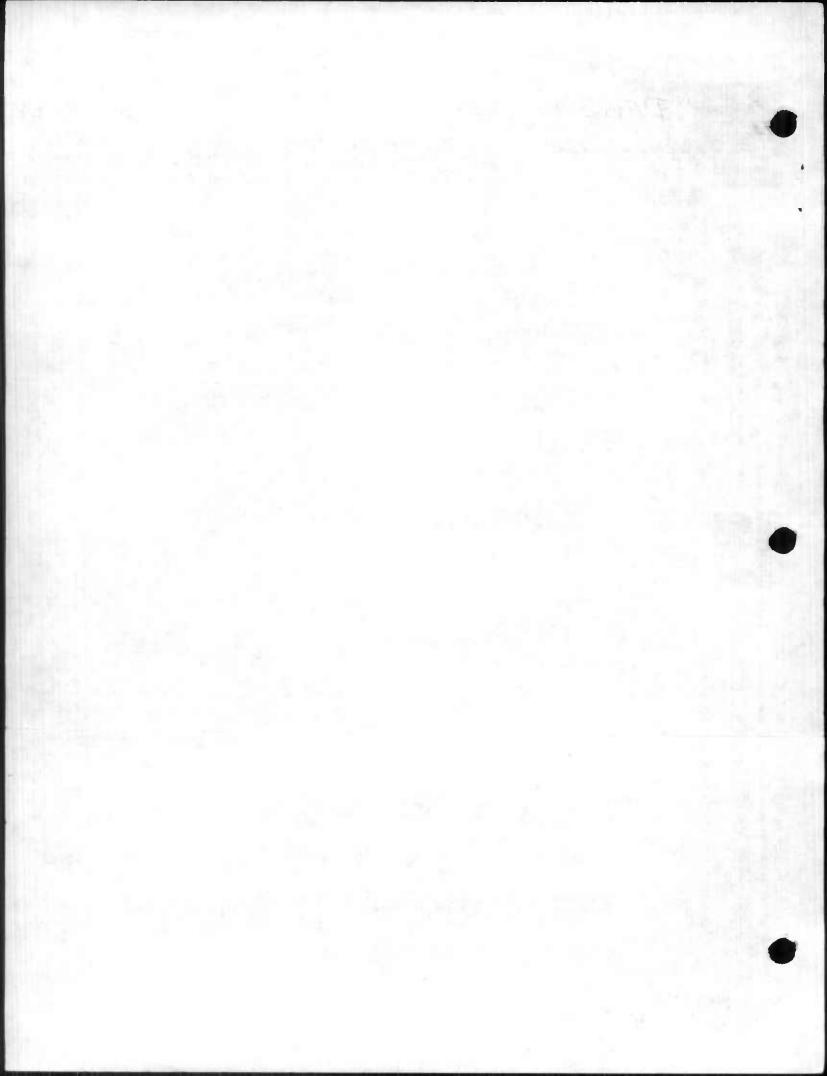
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 0 6 4

		Certificate	of Death	Reg.	No.	
1. Decedent's Name (First, Middle, L	ast)			2. Dete of Deeth Month	Day Yeer	3. Time of Death
ter 4e Facility Name (If not institution, gr	ive street end number)	2 Controp	4b. City, Town, or	Location of Deeth	4c. County of Dea	more
5. Social Security Number 6. 578-24-6945 Usuel Residence of Decedent	Sex 7. Age (In yrs. laft	birthday) If Under 1 Yrs. Months C	eys Hours Min	8. Dete of Birth	9. Bir	thpleca (Stete or Foreign ountry)
10a. Stete 10b. County	10c. City, To	own or Location	(87	10d. Inside City Limits
Mary May Balta 10e. Street and Number 9317 Lyuns 6 11. Meritel Status	wood Drive	101. Zip Co		10g.	Citizen of What Co	ountry?
3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No HY9s, Give Year or Detes:	13. Wes Deceden If Yes, specify	of Hispenic Origin? (S Cuben, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Bleck, Whi	
15. Decadent's 6 (Specify only highest g Elementery/Secondary (0-12)		6a. Decedent's Usual C (Give kind of work of life. DO NOT use if	lone during most of wo etired)	rking	Nind of Business	Andustry CDV3 kg
17. Father's Name (First, Middle, Las	1)			me (First, Middle, Mai	den Sumame)	
19e. Informent's Neme/Reletionship HELEN DICKETS 20a. Method of Disposition 1 □ Buriel → Cremation 3	CAYE POULTED Removal from State	9b. Melling Address (S 93/7 Ly a of Disposition (Neme stery, cremetory or othe VACUANT CO	treet end Number or R	Dete 200	Swings // C. Location - City or	nills, nud
21. Signeture of Funeral Service Lice 23a. Pepf. Enter the disease, or conshock, or heart feilure. List only immediate Ceuse (Finel disease or condition		BoltInu	ddress of Fecility Charles of STEV shows of Newry 1st dying, such as cardia	x0 21215		Approximete Interval Between Onset end Deeth
resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b. Aleoso Due to (or as	a consequence of): a consequence of): a consequence of):	Cadin	مالاتوسال		
Pert II. Other eignificant conditions	contributing to death but not resulting	a in the underlying cau:	se given in Pert I.	23b, Did tobe	cco use contribut	te to the cause of death?
Utrey.	se Psychol	ere Dr	scare	1 □ Yee	2 No 3 F	Probably 4 Unknow
Completed				24e. Wes en e performed	d?	Were eutopsy findings eveilable prior to completion of cause of deeth?
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	22.10	15,100 15,110
O 1 Yes 2 No	(Month, Day Year)		Other: 4 Nersing Injury at Work? 1 Yes 2 No	fome 5 ☐ Residence 28d. Describe how		ecify)
3 Suicide 6 Could not determine	be d 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, c	ffice	28f. Location (Stree City or Town, S	et end Number or F litete)	Rurel Route Number,
	hysician: To the best of my knowled miner: On the basis of examination end menner stated.					
29b. Signeture and title of certifier	RKwon	29c. L	icense number	3 29d.	Date signed (Mon	nth, Day, Year)
30. Neme and address of person who	completed cause of deeth (Item 23	a) (Type, Print)	Word	e. 17.9	low	21208
State 31. Date filed (Month, Dey, Year)	32. Registrer's Signeture		الدوري	e, 17 a	Lon	5150



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** 37 SHERMAN ADAMS NOV 2000 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CENTE SALISBURY HEAD Wicomico eers 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 11 M 2□ F Deys Months Hours 213-22-9266 Director 7/22/1928 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 XYes 2 □ No Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Dover Street 21804 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 [2K/es 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ XNo ģ 3 Widowed 4 Divorced Specify white Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic avenue. Elementary/Secondary (0-12) College (1-4or 5+) Firefighter City of Salisbury 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace Seth Adams N. Pearl Beard 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane A. Adams (wife) 500 Dover St., Salisbury, MD 21804 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/7/00 Salisbury, Maryland 21. Signature of Funeral Servica Licage 22. Name and Address of Fecility Holloway Funeral Home, P.A. 501 Snow Hill Road, Salisbury, MD 21804 altene 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse or each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel 5# URS disease or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown HEPATIC INSUFFICENCY bengis d be del Records, þ Completed 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? MUSCLE WASTING page 2 this certificete 1 ☐ Yes 2 ☐ No Vital after death.

Director: After this certifice director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No Division of funeral 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Tes 2 No 2 Accident Investigation 6 Could not be determined within 24 hours after der To the Funeral Director completely filled in by th 3 Suicide 26f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) To the 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) D33905 -mp mos 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) POBOX 2018 Salis BURY Md 21802-2948 IRGINIA A Dulany mo 31. Date filed (Month, Day, Year) 32. Pagistrer's Signature State NOV 0 6 2000 Registrar

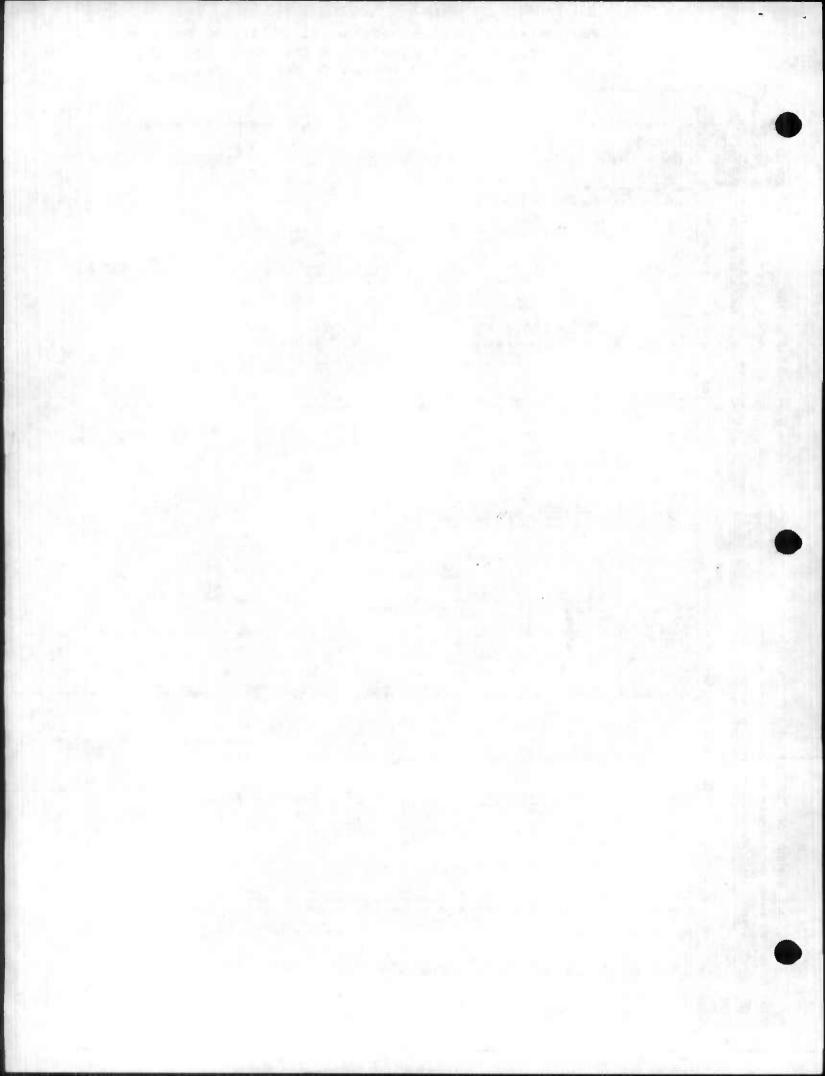
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State of Maryland / Department of Health and Mental Hygiene 00 37066

			C	Certificat	e of i	Death		Reg. No.		
	1. Decedani's Name (First, Middla, Las	t)	0.00				2. Date of			3. Tima of Death
Physician	Frederick W. Adle	r					Month	ber 1, 20	Year 000	8:10 pm
/Medical	4a Facility Nama (If not institution, give				4	4b. City, Tov	wn, or Location of De			0.10 pm
Examiner	10011 Sutherland						r Spring	Montg		7
-	5. Sociel Security Number 6. Sec		rs last hirthr	fav) If Under	1 Year	If Undar 2				placa (Stata or Foreign
Funeral Director	568 20 4344	⊠M 2□F 78		Months	Days	Hours	Min. (Month,	Day, Year) ary 11,19	Cour	Illinois
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ther death with the Marylar ribers 23s or 28s-f show siner must be notified at Funeral Director	Maryland Montgom			Spring						1 □ Yas 2€ No
or at	10e. Street and Number			10f. Zip	Coda			10g. Citizan of V	What Cour	ntry?
M SS M	10011 Sutherland	Road		20	0901			USA		
Je de	11. Marital Status	12. Was Decedent Evar in Armed Forcas?	U,S.	13. Was Dece	dent of H	lispanic Orig	gin? (Specify Yas or , Puarto Rican, etc.)	No- 14. Rac		can Indian,
one. than *natural*, or thems 22s or 28s-f show the Medical Evanriner must be notified at ompleted by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yas, Giva 192 Year or Datas: 192		1 ☐ Yes		Specify:	, Poarto Ricari, etc.)		ok, Whita, /: Whit	
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refere. Tr. the Medical Completed	(Specify only highast gra-	da complated)	100	Giva kind of wo	rk dona	durina most	of working	Medical		
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44	4 ☐ Donation 5 ☐ Othar (Specify		arklaw	n Memo:	rial	Park	10,2000	Rockvi	lle,	Maryland
imports any inju	21. Signature of Funaral Sarvice Licen	See Pohlo		Francis 500 Un	d Addra	ss of Facility COIII	ins Funera Blvd. West	1 Home,	Inc. Sprii	ng,MD 20901
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	23a Part 1. Enter the diseasa, or comp shock, or haart failura. List only	ona causa on each lina.								Intarval Batween Onset and Death
ysician Iedical	Immediata Causa (Final									
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nding physician and use as the burial-transit	Sequentially list conditions,	Dua to	(or as a cor	nsaquance of):						
Lian I	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury									
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d for use	Part II. Other significant conditions of	entributing to death but not r	asulting in th	na undartvino d	causa niv	en in Part I.	23b. D	ld tobacco use co	ntributs t	to the cause of death?
d by the attend letached for us. Physician/										bably 4 Unknown
signed by the atte d be detached for d by Physicia								_ 160 Z.D.NO		
S S S							24a. W	as an autopsy	24b. W	are eutopsy findings
page 2 should t							pe	rformed?	CO	vailabla prior to empletion of causa
has mp									Of	death?
Co Dag							1	☐ Yas 2 ☑ No	1	☐ Yes 2☐ No
ector: After this certificate has by the funeral director, page 2 lification: To Be Comp	25. Wes case rafarred to medicel examiner?						of Deeth (Check on	ly ona)		
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or death. octor: After by the fune iffication	2 Accident invastigation			М		Yes 2□P	No			
after death. Director: After I in by the fune ertification	3 ☐ Sulcide 6 ☐ Could not be determined	288. Place of injury - A	homa, farm	, straat, fector	y, office	7411		n (Street and Numb Town, State)	ber or Run	al Routa Number,
uneral Director: After the funeral property filled in by the funeracal Certification:	→ □ Hornicioe	building, afc. (Spe	спу)				City or	Jenn, State)		
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T 0		iner: On the basis of axanteend mannar stated.	nation and/o	or invastigation	, In my o	pinion, daat	th occurred at the tin	a, data and place,	and due t	o the cause(s)
To the Fucomplete	29b. Signature and this of certiller	1 /		29	c. Licans	a number		29d. Data signe	d (Month,	Dey, Year)
2011	1 /d/)1	1. //0	1						1	
1011	116	WW D	2		0785	0		November	2, 2	2000
4	30. Name and address of person who	completed causa of daath (I	tem 23a) (Ty	ype, Print)						
	Dr. H. Lyndon M			1 Aven	ue,	Suite	270, Take	oma Park,	MD	20912
State	31. Date filed (Month, Day, Year)	32 Registrer's Sk		1						

Registrar



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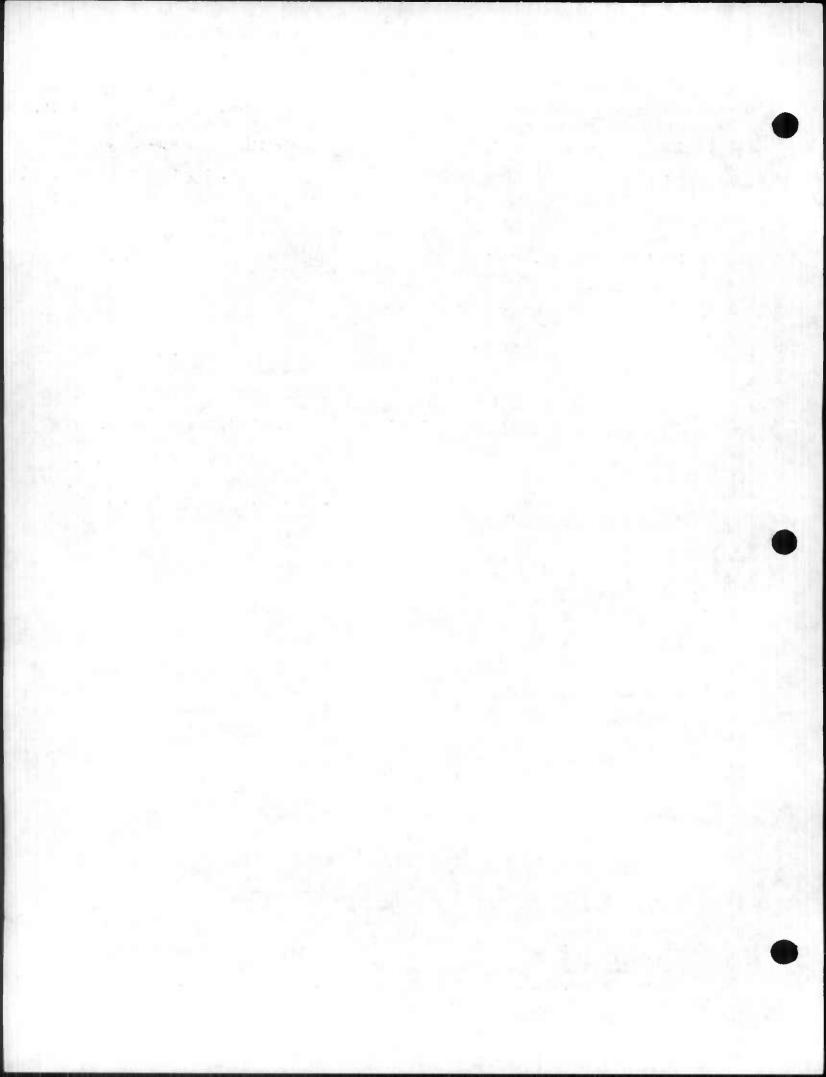
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State of Maryland / Department of Health and Mental Hygiene

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		1 P. Tale	an M.D.			D36552		Novembe	r 6.	2000
	50	30. Name and address of person who can Talwar Pankaj, M	ompleted cause of deeth (Ite		Print)	R., Rock	cville, N			
	State Registrar	31. Dete filed (Month, Dey, Year)	32. Registrer's Sign		South					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Dav **Physician** Jerome Milton Alper 3, 2000 Nov. 2:35P. /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 7702 Rocton Avenue Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. last birthday) **Funeral** Months 10XM 20 F 577-54-1684 86 New York Director Aug. 26, 1914 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Franking must be notified at Maryland Montgomery Chevy Chase 1 XYes 2 No Directo 10e. Street and Number 10f. Zio Code 10c. Citizen of What Country? 7702 Rocton Avenue 20815 United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1∰ Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Medtel Stetus Bleck, White, etc. o filed within 72 hours after of Hygiene. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: p 3 Widowed 4 □ Divorced White Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Busineas/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementery/Secondery (0-12) Lawyer Law permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, Important: If fam 27 is marked othe any Injury or other traumatic evant, bace. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be David Samuel Alper Ethe1 Gordon 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Name/Relationship (Type, Print) Alan Alper (son) 1049 Park Avenue, #9-A New York, New York 10028 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State King David Memorial Garden 11/6/00 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23 part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch es cardiac or respiretory arrest, shock, or heert tailure. List only one ceuse on each line. Approximete tritervel Between Onset and Deeth **Physician** Pancreatic immediate Ceuse (Final disease or condition resulting in death) 3 weeks /Medical (ancer Examiner Due to (or as a consequence of) Examine attanding physician and for use as the burial-transit that the death certificete be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted eventa resulting in death) Last Due to (or ea e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): 88 ed by the a P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by I should be detach 1 Yea 2830 3 Probably 4 Unknown Division of Vital Records, by The law requires 24a. Wes en autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? has page 2 1 ☐ Yea 2 ☐ No certificate Physicien: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this funeral 28a. Date of Injury (Month, Dey Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Natural or Attending s after deam. 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral [Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

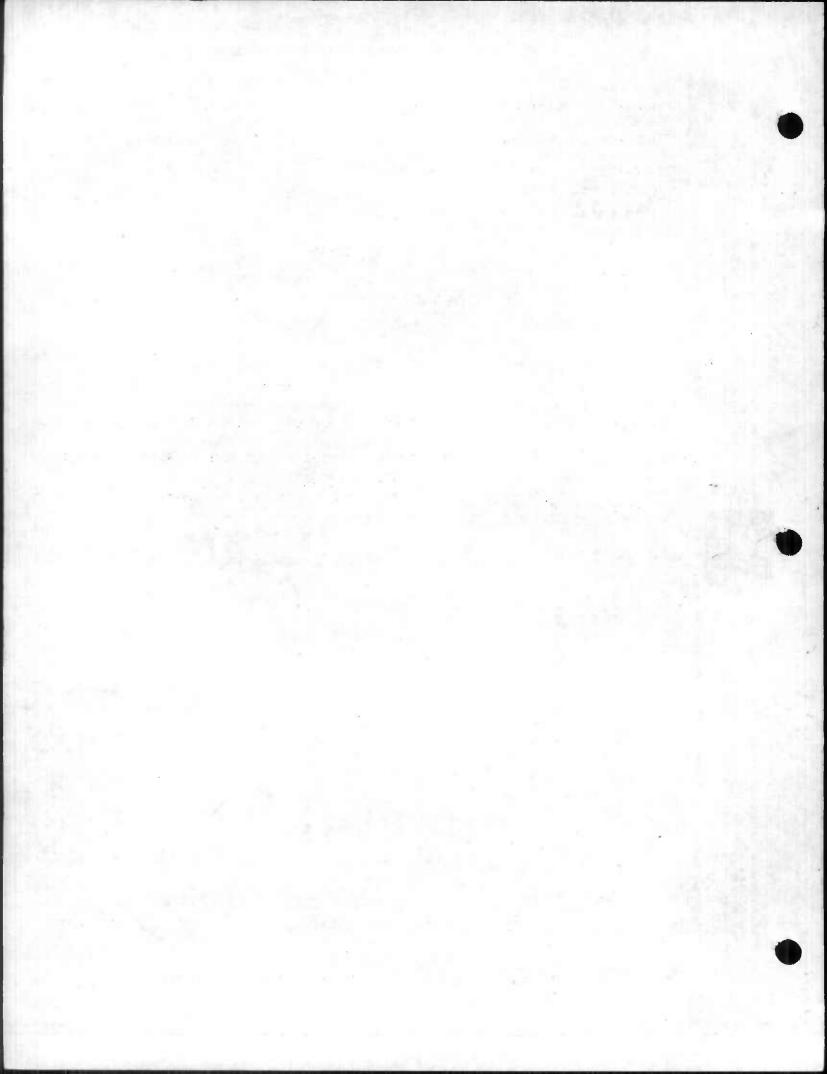
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai pletaly 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 6, 2000 Me 1144

State Registrar

31. Date filed (Month, Dey, Year) 2000 NOV G 7

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)
Richard Schubert, M.D. 3301 New Mexico Avenue, #348, N.W. Washington, D.C. 20016 32. Registrar's Signature

souks



Hospital or Attending Physician: Division death.

Medical Certification: To After Director: /

27. Menner of Deeth 28c. Injury at Work? 5 Pending invastigation 1 Neturel 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 | Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Will Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number

M./

30. Name and addrass of purson who completed cause of death (Item 23a) (Type, Print) MARY G. RIPPLE

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

November 09, 2000

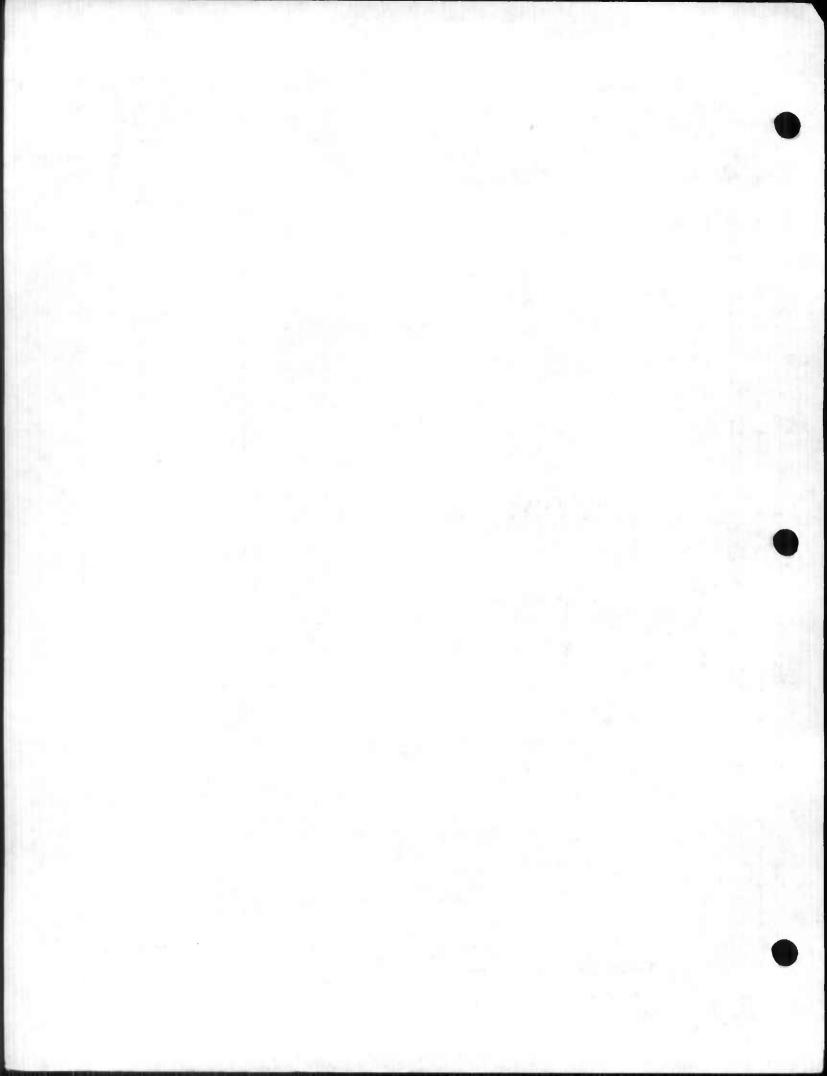
Registrar

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To the Hospital within 24 hours a To the Funeral Completely filled

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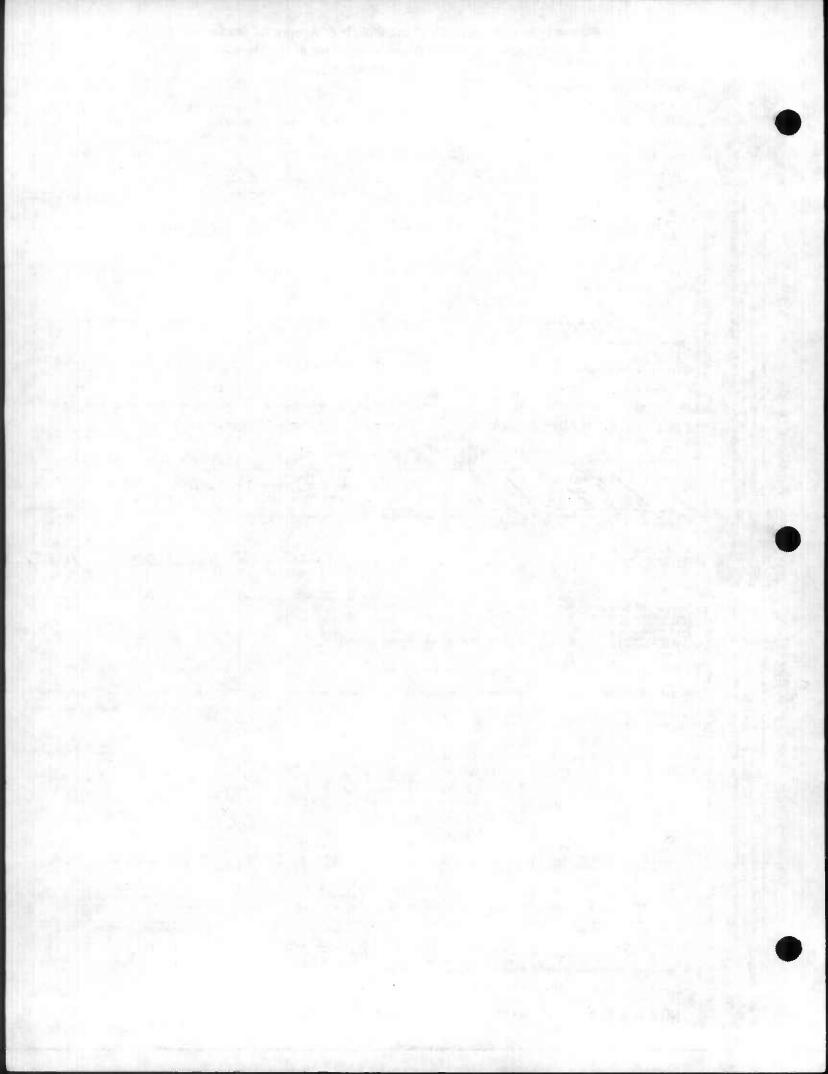


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State of Maryland / Department of Health and Mental Hygiene 0 0 3707 |

Certificate of Death

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Cecil	
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	10d. Inside City Lin
	1 Yes 2 □
10g. Citizen of What (
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16b. Kind of Busines	
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ber, City or Town, State	e, Zip Code)
Maryland 21	921
20c. Location - City	
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how injury occurred	
(Street and Number or own, State)	r Rural Route Number,
e cause(s) and manner e, date and place, and c	r es stated. dua to the cause(s)
29d. Date signed (Mo	lonth, Day, Year)
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9	e cause(s) and manne e, date and place, and



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State of Maryland / Department of Health and Mental Hygiene 00 37072

		Certificate of Death Reg. No.											
		1. Decedent's Neme (First, Middle, L	1. Decedent's Neme (First, Middle, Last)				2. Date of				3. Time of Deat	h	
	Physician	Claude Edward Bayneum				Nove			ember 3, 2000		0820		
	/Medical Examiner	4a Facility Name (ff not institution, give street and number)				4b. City, To		ation of Death					
4	Examiner	Mallard Bay Nursing Home				Cambr	idae		Dorchester				
	Funeral	5. Sociel Security Number 6.	if Under 1 Y	ear If Under		8. Dete of Birth (Month, Dey,			irthplace (State or Foreign Country)				
	Director	214-16-4920 Usual Residence of Decedent	30 Yrs.	Months D	s Deys Hours Min. (Month, Dey, Year) December 30,				, 1919 Maryland				
		10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Lim										nits	
1		Maryland Dorchester Cambridge						1 ⊠ Yes 2 □ No 10g. Citizen of What Country?					
3						101. Zip Code 21613				US			
020	af, or he Examiner	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in Armed Forces? 1 □XYes 2 □ No If Yes, Give Yeer or Detes:	Armed Forces? If Yes, 1 □ Yes 2 □ No If Yes, Give 1 □ Y			Decedent of Hispenic Origin? (Specify Yes or Nes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No Specify:			No- 14. Race - American Indien, Bleck, White, etc. Specify: Black			
Maryland 21215-0020	ed within 72 hours ygiene. we than "natural"; x, the Medical Exa Completed by	15. Decedent's (Specify only highest of	de completed) (Give kind of work			k done during most of working			16b. Kind of Business/Industry				
	than the Mo	Elementary/Secondary (0-12)	College (1-4or 5+)	College (1-4or 5+)		OO NOT use retired)			Food Service				
			nel	u		200K							
/land	Mental H Mental H rked off fic ever	5	Lewis Henry Bayneum							ne (First, Middle, Maiden Sumeme) Lizabeth Cromwell			
6	2 sho and h is ma	19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip C								Code)			
	ar transfer	Sarah Norma Lee Jon					mbridg	e, Maryla					
	Pages 1 tent of Hs rrt: If Iten rry or oth	20e. Method of Disposition 1 💢 Buriel 2 🗆 Cremation 3	Removal from State		metory or other	plece)	1		20c. Location -				
E	of many of the party of the par	4 □ Donetion 5 □ Other (Special Services Lice)	4	4				11/8/00 Hurlock, Maryland					
Ba	Dept.	Maryland 21613 Mattie 2 Boardley Funeral Home 812 Hubbard St. Cambridge,											
		23a. Part1. Enter the diseese, or co shock, or heart failure. List on	eath. Do not en	enter the mode of dying, such as cerdiac or respiretory				Interval B		Approximate Interval Between Onset end Deeth			
) I	Physician /Medical	Immediate Cause (Final											
	Examiner	disease or condition a. Acute Myocardial Infarction immediate classified immediate classes or condition immediate classes or								immediat	e		
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x 68760,	2 0 0	resulting In death) Lest	Due to (or es a consequence of):										
Rox	igned by the attendii be detached for use by Physician/							l net Dida	not Didashage and the same				
ָ	by the by the lached	Part II. Other significant conditions contributing to death but not resulting in the			the underlying ceuse given in Pert I.				23b. Did tobacco use contributs to the causs of death? 1 🖾 Yes 2 🗆 No 3 🗆 Probably 4 🗀 Unknown				
	signed b	Chronic OBSTRUCTIVE Pulmonary Disease						TATES ZEING SEPTONOMY 4 CONNIC				IOWII	
COLGS	requir							24a. Was e		cor	ere eutopsy findin eilable prior to mpletion of cause death?		
T G	The law sate has be page 2 s							1 □ Ye	s 2 No		Yes 20XNo		
Ia	certificate rector, page Co												
>	Physicien: this certific ral director,										v)	10	
o uc			28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work?					28d. Describe how injury occurred					
	or Attendent deat Sirector: in by the	2 Accident investiget 3 Suicide 6 Could not 4 Homicide determine						28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
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	within 2 To the comple	one) end manner steted. 29b. Signature and title of cartifies 29c.				∂c. License number			29d. Date signed (Month, Day, Year)				
	5 % C 8	1. H	S. S						11/08/00				
								11/0	0100	/			
			30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Timothy J. Sniezek MD 503-A Muir Street Cambridge, Maryland 21613										
	State			anatura	, ,		age,	,	.5 2101.				
	Registrar		2000 Sener	10	· do	ochs							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Year Month **Physician** GARY DONALD BATEMAN 4c. County of Death November 1025 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner Talbot The Memorial Hospital Easton If Undar 24 Hrs. If Inder 1 Vear 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Deys 1 M 2 F 215-54-6194 50 Yes Director Nov 17 1949 Virginia Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits MD Caroline Federalsburg 18 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 708 Routzhan Lane 21632 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritel Status Bleck, White, etc. 1 ☐ Never Merried 2 Merried 1 Yes 2 No Specify: Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Don Cubiotte Bateman Lucille 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 701 Race. St. Cambridge MD 21613 Betty Lou Bateman - wife 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremation 3 Removel from Stete 11-4-2000 Salisbury, Md. 4 ☐ Donetion 5 ☐ Othar (Specify) Salisbury Crematory 22. Name and Addrass of Fecility Thomas Funeral Home PA 21. Signeture of Funeral Service Licensee 700 Locust St. Cambridge MD 21613 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Intervel Between Onset end Deetl **Physician** Immediate Ceuse (Final disease or condition resulting in death) a 4da /Medical SED SIS Examiner Due to (orles e consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es a consequence of) Physician/Medical Due to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Completed 2 000 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medicel Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 | Yes 2 | Die 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: Injury at Work? 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide

certificate be axecuted Box 68760 Division of Vital Records, P.O.

The law requires that the death Physician: s efter death. or Attending within 24 hours e To the Funeral C completely filled Hospital

28a-f show must be notified at

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Name 23a

r than "natural", or iten the Medical Examiner

Hygiene.

Ospartment of Health and Mental Hygi Important: If them 27 is marked other way injury or other

attending physician end for use as the burial-transit

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29a. Certifier (Check only one)

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Pages 1 and 2 should be nent of Health and Mental

with the

Maryland 21215-0036

Sary Bateman

State Registrar

Dr. Jeanine Einfalt, 31. Deta filed (Month, Dey, Year)

NOV 0 6 2000

29b. Signature and title of cortifier

30. Name and address of purson who completed cause of deeth (Item 23a) (Type, Print) 219 S. Washington St. Easton MD 21601

32. Registrar's Signeture

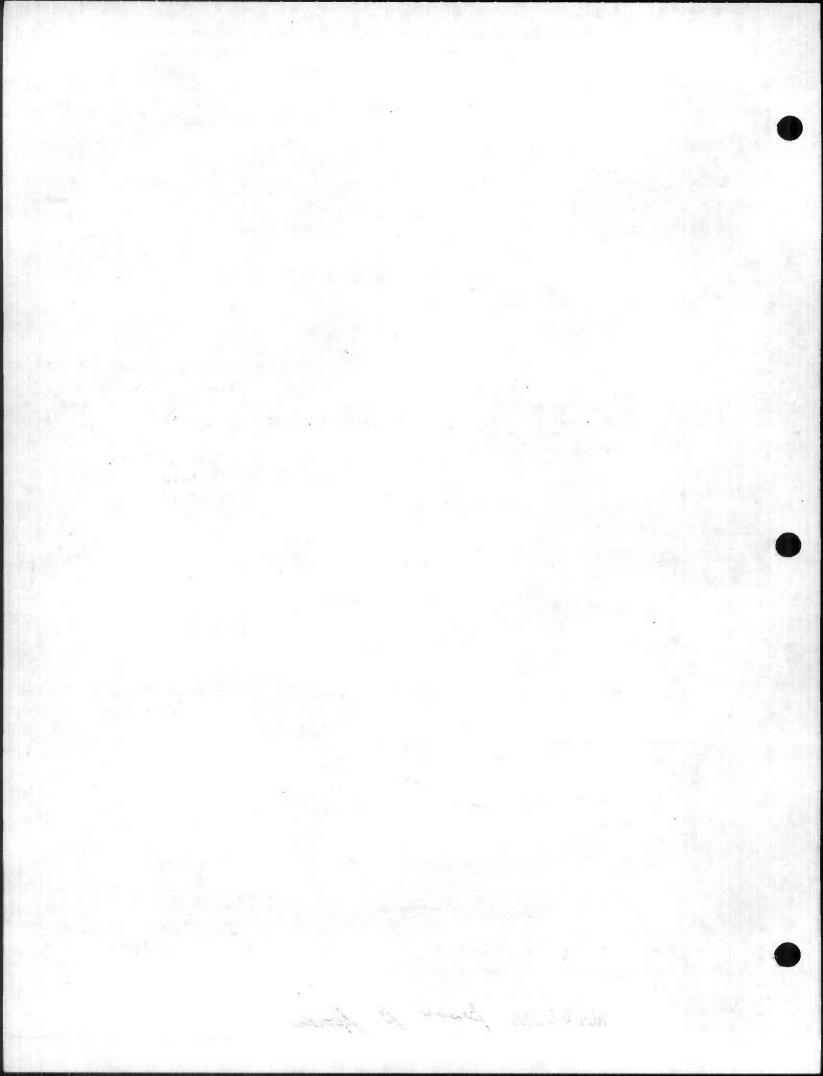
To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as atlated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. Licensa number

29d. Date signed (Month, Day, Year)

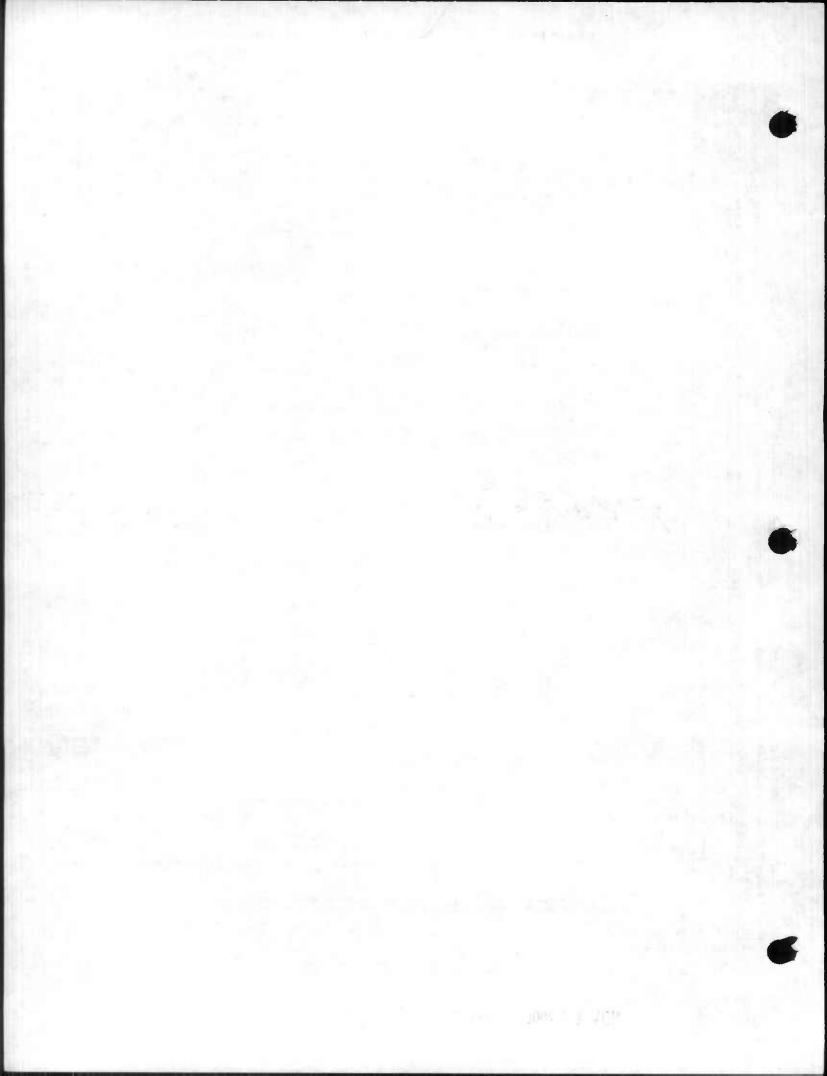
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State of Maryland / Department of Health and Mental Hygiene

and Mental Hy	giene	nr	3	7	0	7	1
	Reg. No.	00	, ,	1	U	1	E.

	Certificate of Death	Reg. No.
	Decedent's Neme (First, Middla, Last)	2. Data of Deeth 3. Tima of Death
Physician	Karen Coblentz Baker	November 11,2000 1:30PM
/Medical Examiner		or Location of Deeth 4c. County of Death
LXammer	12741 Pearson Drive Waldo	orf Charles
Funeral	5 Social Security Number 6 Sev 7 Ame (to use fact highdress) If Under 1 Year If Under 24	Irs. 8. Deta of Birth 9. Birtholaca (Stata or Foraign
Director	579-90-5877	in. (Month, Day, Year) Feb. 4,1963 France
-	Usual Residence of Decedent	reb. 4,1905 Flance
25a-t show notified at ector	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
fied for	Maryland Charles Waldorf	1 ☐ Yas 2 ☐ No
be notified	10e. Street and Number 10f. Zip Coda	10g. Citizen of Whet Country?
	127/1 Boomson Duizzo	77 6 4
iner must	12741 Pearson Drive 20602 11. Marifel Status 12. Was Decedent Ever In U.S. 13. Wes Decedent of Hispanic Origin?	(Specify Yas or No- 14. Reca - Amarican Indian,
Par Par	11. Marifel Status 12. Was Decedent Ever In U.S. Armed Forces? 1 Never Married 2 Merried 12. Was Decedent Fuer In U.S. Armed Forces? 1 Yes, specify Cuban, Maxican, Pu	arto Rican, atc.) Black, Whita, atc.
P. or	If Yas, Gwa 1 □ Yes 2 No Specify: 3 □ Widowed 4 □ Divorced Year or Detes:	Specify:
	15. Decedent's Education 16e. Decedent's Usual Occupation	White 16b. Kind of Business/Industry
nt, the Medical Completed	(Specify only highest grade completed) (Give kind of work done during most of	working Too. I wild of Business modelity
the Min	Elementary/Secondary (0-12) College (1-4or 5+)	minion Madianl Institut
PH O	- Radiological icen	nician Medical Imaging Name (First, Middle, Maiden Surnama)
rked off		
marka		beth Mc Murray
# 2		Rural Route Number, City or Town, Stata, Zip Code)
12.7 10.1	Harry R. Baker / Husband 12741 Pearson Dri	ve Waldorf MD 20602
in o	20a. Mathod of Disposition 1 □ Bunial 2 Cramation 3 □ Removal from Stata	NOV . 20c. Location - City or Town, Stata
2 ++ 2	4□Donation 5□Other (Specify) Brinsfield-Echols Cr	.18,00 Charlotte Hall,MD
mportant my injury ance.	21. Signature of Funeral Service Licensee	
o year	B B	rinsfield-Echols F.H.,P.A.
	P.O. Box 128 Ch	arlotte Hall, MD 20622
	23a. P.m1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care mock, or heart failure. List only one dause on sections.	Interval Batween Onsat and Death
sician edical	Immediate Course (Final	
edicai iminer	Immediate Cause (Final disaasa or condition rasulting in death) Lung Cancer with metastasis	to brain
	Dua to (or as a consequence of):	
in and hal-transit Examiner	a b	
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	Sequentially list conditions, if arry, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initieted events Dua to (or as a consequence of): C. Dua to (or as a consequence of):	1
£ 2 ≥	that initieted events resulting in death) Last Dua to (or as e consequence of):	
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ed by the atte detached for detached for detached for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.	23b. Did tobacco use contribute to the cause of death?
by the tached		1 Yes 2 No 3 Probably 4 Unknown
igned by the attend be detached for us by Physician/		_
should be det		24a. Was an autopsy 24b. Were autopsy findings
shou		parformed? aveilable prior to completion of cause
5 U F		of death?
s certificate ha director, page To Be Com		1 Yas XXNo 1 Yas 2 No
ctor,	25. Was case reterred to medicat axaminer?	Death (Check only ona)
	Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursin	g Home Rasidance 6 Othar (Specify)
After this funeral di	27. Mapper of Death 28a. Data of Injury 28b. Tima of 28c. Injury at Work?	28d. Dascribe how injury occurred
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To the Funeral Director: Affart completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be 28a Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Routa Number,
Pre In	4 ☐ Homicide building, atc. (Specify)	City or Town, State)
To the contract of the contrac	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl	ace, and dus to the cause(s) and manner as stated
Pletely fill	(Check only 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death o one)	
M P	29b. Signatura and titla of certifiar 29c. Licansa number	29d. Data signad (Month, Day, Year)
¥ 8 _	Alexander of the second	
	1944 Malla D28352	November 11,2000
	30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)	
	Krishan Mathur, MD., P.O. Box 1703, La Pla	ta, MD 20646
State	31. Dete filed (Month, Day, Year) 32. Registrar's Signatura	
Registrar	NOV 1 4 2000 Server B. Sporker	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Evelyn Weinstein Bushwick November 16, 2000 6:36 P. /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 6276 Clearwood Road Bethesda Montgomery If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys June 24, 1924 Months Hours 10M ARE 179-22-2393 Washington, D.C 76 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits "natural", or items 23e or 28s-f show edical Examiner must be notified at Maryla Maryland Montgomery Bethesda 1 Yes 2 No Director 8 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6276 Clearwood Road 20817 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Never Merried 2 Merried 1 ☐ Yes 2 No If Yes, Give 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 4 3 Widowed 4 Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiens. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) 88 h and Mental ? 2 Pages 1 and 2 should be ment of Health and Menta lant: If New 27 is marked Max Weinstein Sylvia Scurnick 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Bushwick-Malloy (daughter) 11103 Slye Ct. Silver Spring, Maryland 20902 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit, Pages Department of Important: If It any Injury or abbs. 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Judean Memorial Gardens 11/19/00 Olney, Maryland 22. Name end Address of Fecility
Donald V. Borgwardt Funeral Home, P.A. 21. Signetyke of Funeral Service Licensee 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediete Ceuse (Finel disease or condition resulting In deeth) METASTATIC LUNG- CANCER

Due to (or es e consequence of):

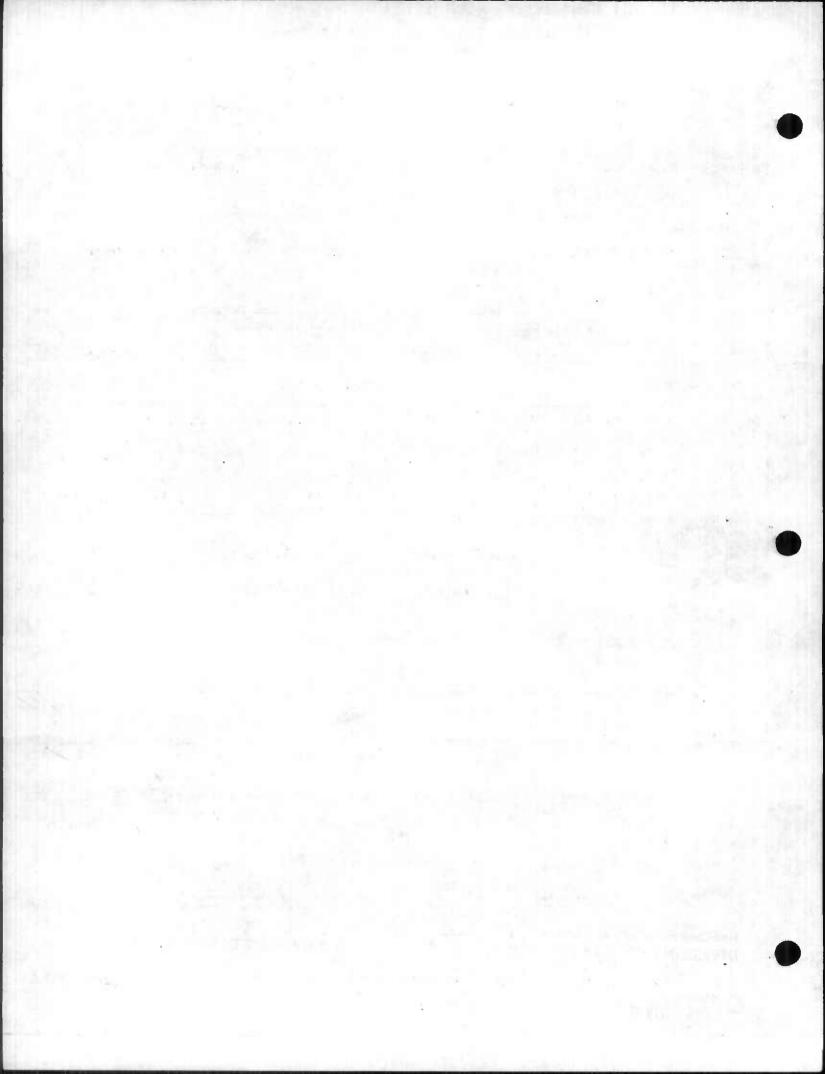
PRIMARY CUNG- CANCER /Medical Examiner Examine attending physician and for use as the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or es e consequence of) ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vitai Records, by 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed Deed page 2 s has 1 Yes 2 No certificate Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this After this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death
1. Neturel
2 Accident 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation after deeth.

I Director: Aft
d in by the fur 1 Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours aff To the Funeral Di completaty filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and menner stated. 29a. Certifier 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier November 17, 2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Joseph M. Haggerty, M.D. 9707 Medical Center Dr., #300 Rockville, Maryland 20850 31. Dete filed (Month, Day, Year) NOV 2 2 2000 32. Registrer's Signeture State Registrar

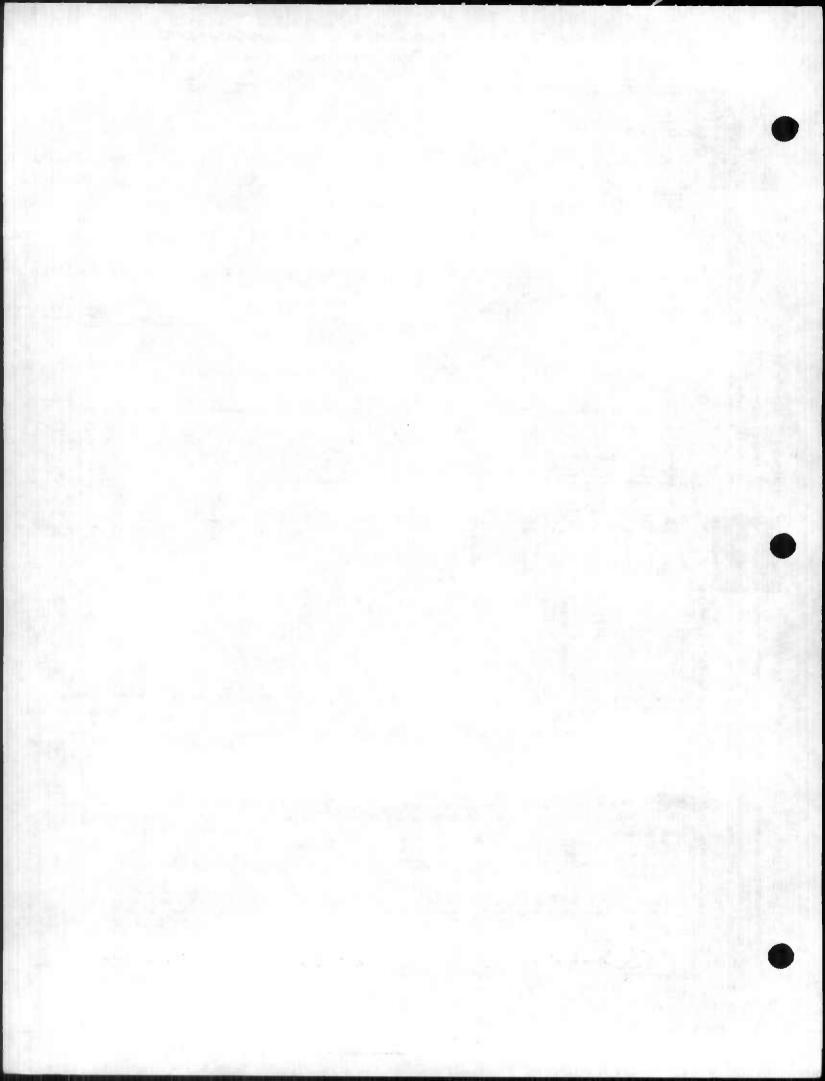
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Physician	1. Decedant's Nama (First, Middle, L					2. Date of De Month	Day	3. Time of Death				
/Medical	Sylvia Pope Br					Novembe						
Examiner	4a Fscility Name (If not institution, g	ive street and number)			4b. City, Town, or L	ocation of Death	4c. County of	f Death				
	Montgomery Hos				Rockville		Montgo					
Funeral		Sex 7. Aga 1 M 2 XF	(In yrs. last birth	Months Days		8. Data of Bir (Month, Da	th y, Year)	9. Birthplaca (State or Foreign Country)				
Director	579-10-6087	TE W ZULT	86 Yr	5.		Nov. 26	, 1913	West Virginia				
2	Usual Rasidanca of Decedant 10a, State 10b, County		10c. City, Town o	or Location				10d. Insida City Limits				
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o within 72 hours after death with the Maryland joine. Then "naturel", or fame 23e or 28e-f show the Medical Enterine must be notified at completed by Funeral Director.	Maryland Montgo	mery	Rockvil	7								
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ra 23	727 Wilson Avenu			20850			United S					
r flams 234 stret must Funeral	11. Marital Status	12. Was Decedent E Armed Forcas?		Was Decedant of If Yes, specify Cul	Hispanic Orlgin? (Sp ben, Maxican, Puarto	ecify Yes or No Rican, etc.)		- American Indian, , Whita, atc.				
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ref. o	3 Midowed 4 □ Divorced	Year or Datas:					White					
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then.	Elementary/Secondary (0-12)	Collega (1-4or 5-	+)	ife. DO NOT use retin	9d)							
Hygier the truther the Cor		4	Tea	cher				ary School				
Be very	17. Fathar's Name (First, Middle, Las	it)			18. Mothar's Nam	e (First, Middle	, Maiden Sumame					
ond Mental or marked or umatic ave	George Edward Po	pe			Ida Sue							
and	19a. Informant's Name/Relationship	(Type, Print)	19b. A	Mailing Addrass (Stree	at and Number or Rui	ral Route Numb	er, City or Town, S	State, Zip Code)				
and 27 in the first	Jacqueline B. Go	rdon/Daught		65 Peach (Orchard Ro							
T Be T	20a. Method of Disposition 1X Burial 2 Cramation 3	Domewalder State	20b. Place of D	isposition (Name of crematory or other pla	aca)	Data Nov 14	20c. Location - C	City or Town, Stata				
rages nert of ment of my or o	4 Donation 5 Other (Spec		Arlingt	on Nat'1			Arlingto	n, Virginia				
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SEES	31.	D	M00803	Rockville Rockville	Inc. 30	0 West	Montgome	ry Avenue				
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Examiner	diseasa or condition rasulting in daath)			1 Failure				3 Months				
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rificate be executed g physician and as the burial-transit fedical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Dua to (or as a co	nsequance of):								
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physicians the burn	rasulting in death) Last		Dua to (or as a co	nsequance of):								
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at the death centild by the attending etached for use a Physician/M												
0 0 0	Part II. Other significant conditions	contributing to death bu	t not rasulting in t	he undarlying causa g	ivan in Part I.	23b. Dld	tobacco use cont	tribute to the cause of death?				
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has by pe 2 st mple								of death?				
ate ha						10	Yas ZE No	1 ☐ Yas 2 ☐ No				
certificate rector, pag	25. Was casa rafarred to medical				26. Placa of Dea	th (Check only	one)					
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tal or Attanding in a steel death. al Director: After ted in by the funeraction: Certification:	4 I Homole	building, atc	. (Specify)			0.1,7 0.1 7 0	m, olalo,					
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	30. Nama and addrass of person wh	completed cause of de	ath (Itam 23a) (T	ype, Print)								
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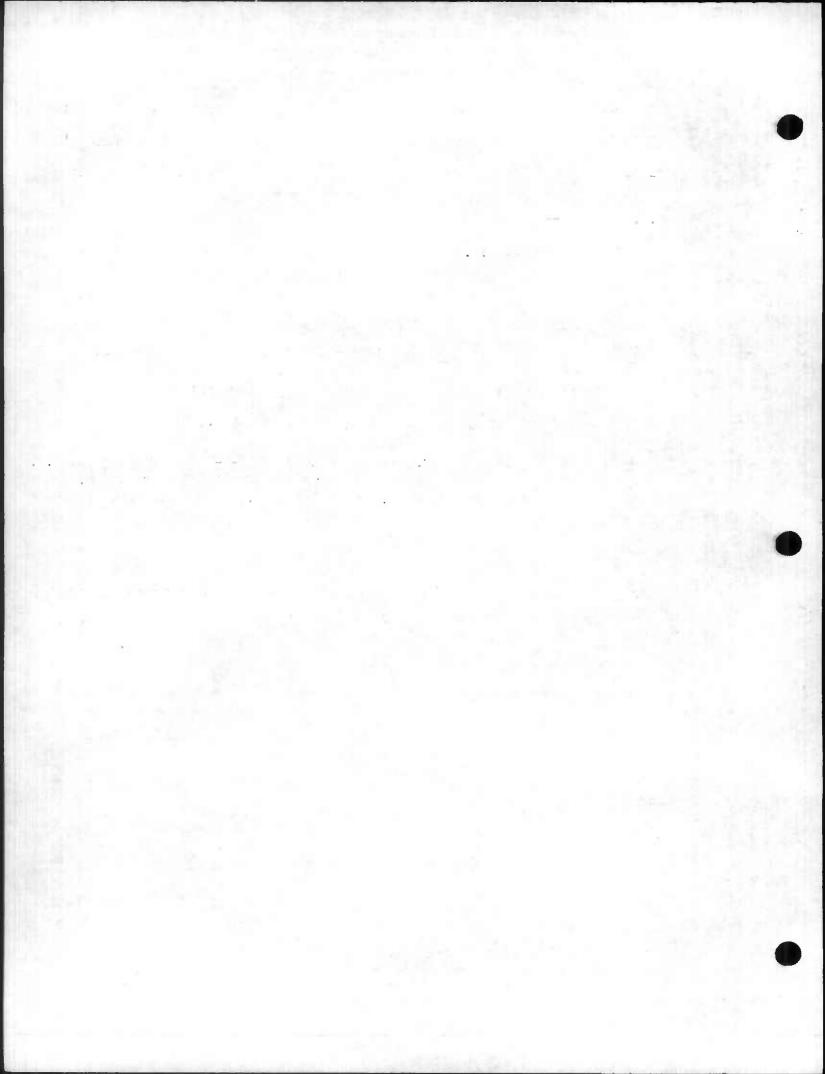
Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** DIEUVEUILLE **BRUNO** 2:45 AM November 3, 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CENTER CLINTON if Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) March 30 1920 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Davs Months Hours Haiti 80 Director 577-34-4436 Usual Residence of Decedant 10a. Stata 10c. City, Town or Location 10b. County 10d, fnaide City Limits 1X Yas 2 No D.C. Washington Director 28a-f 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number flare maint be n 20002 United States 1643 Lang Place, N.E. Funeral 14. Race - Amarican Indian 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, apecify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. the Medical Examiner 1X Yas 2 49 -46 1 Nevar Married 2 Married b 1 Yes 2 No Specify: Specify Black À 3℃ Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Induatry Elamentary/Secondary (0-12) Collega (1-4or 5+) Surgical Technician Medical 18. Mothar's Name (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) 96 Cezias Bruno Aimee Prival 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19e. Informent's Neme/Raletionship (Type, Print) 1643 Lang Place, NE Wash., DC Pages 1 and 3 ment of Health Ginette Suarez/Daughter tant: If Ibem 27 20b. Ptace of Disposition (Nema of cematary, cramatory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) 11-9-00 Washington, D.C. Mt. Olivet Cemetery 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Washington, DC 20002 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** fmmediata Causa (Final disaasa or condition rasulting in death) /Medical de Examiner Physician/Medical Examiner the attending physician and hed for use as the burial-transit Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaase or tnjury Dieuveyill that initiated evants rasulting in death) Last Dua to (or as a consequence of): signed by the aid be detached for 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Wara sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen s Completed has 2 No 1 🗆 Yas 1 ☐ Yaa 2 ☐ No this certificate Be 25. Was casa referred to medical 26. Place of Death (Check only one) axaminar? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 1 Yas 2 No 2 2 ER/Outpatient 3 DOA 28c. fnjury at Work? 27. Magnar of Death Certification: 28b. Tima of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yas 2 No death. nvastigation 2 Accidant eral Director: A 3 Suicida 6 Could not be detarmined 28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 281. Location (Street end Number or Rurel Routa Number, City or Town, Stete) or A 4 ☐ Homicida To the Hospital of within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and mennar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. edical 29e. Certifier 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. Licanse number 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Phot) Clinton, Md 20735 BERU 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

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Registrar

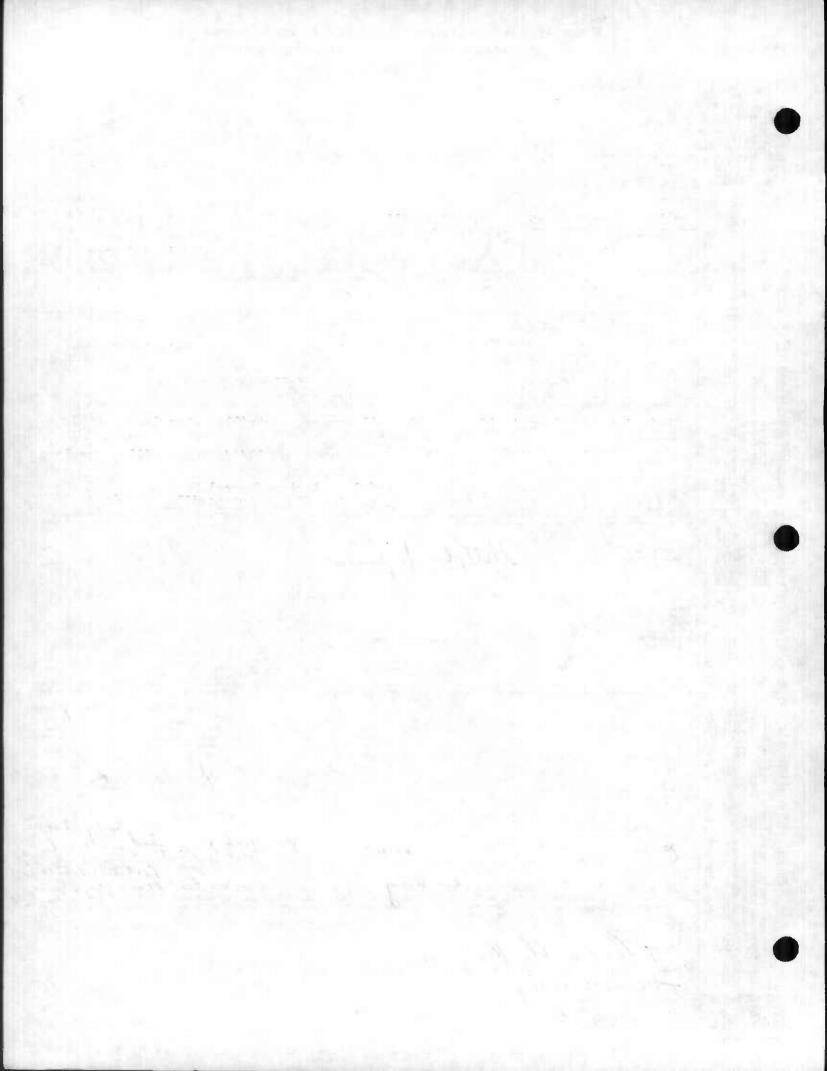
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2000



State of Maryland / Department of Health and Mental Hygiene 0 0 37078

			Cen	tificate of	Death	Re	g. No.	01010				
8 1	1. Decedent's Nama (First, Middle, Last)					2. Dete of Deeth Month	Dev Yea	3. Time of Death				
Physician /Medical	JONATHAN DAVID	BRIGGS		7.76		November						
Examiner	4a Facility Name (If not institution, giva	street and number)			lb. City, Town, or L	ocation of Death	4c. County of De	eth				
	Route 495 ar	nd Ritchie Mar	lboro	Road	Ritchie			George's				
Funeral Director	5. Social Security Number 6. Sex 213-15-8038	7. Age (In yrs. le 1 26	est birthdey) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey, June 13,	9. E 1974 N	Sithpleca (Stata or Fore Country) Maryland				
2 .	Usuel Residence of Decedent	1.0.0%	Townstan					Least on the				
da -	10a. Steta 10b. County		, Town or Loc					10d. Insida City Lim				
cto die	Maryland Montgome	ry R	ockvil	le								
thems 23s or 28s-f showner must be notified at unernal Director	10e. Street and Number 512 Beall Avenu	le		10f. Zip Code 2085	0		10g. Citizen of What Country? United States					
by F	11. Meritet Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Detas:		Ves Decedent of H Yes, specify Cube	ispanic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rece - Ar Black, Wi Specify:	merican Indien, hita, etc. White				
fical fical	15. Decedent's Educ		16a. Deced	ent's Usuel Occup	ation	ring 1	16b. Kind of Business/Industry					
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Menta merked merked To B	John Wesley Bri	ggs			Riellya	inn Unru	h					
and M	19e. Intorment's Neme/Retetionship (Type	pe, Print)	19b. Meiting	g Address (Street	end Number or Ru	ral Route Number,	City or Town, Stele	, Zip Code)				
27 in	Christina C. Brid	as / Wife	512 B	eall Ave	nue. Rock	ville.	Maryland	20850				
if its Hear. or other	20e. Method of Disposition	20b. Ple	ece of Dispos	sition (Name of netory or other plea	(a)	Data 2	Oc. Location - City	or Town, Stele				
E P												
Departmen Important any injury once	21. Signeture of Funerel Service License	Barker	M	Neme end Addre	Barber	uneral H	ome lle, Mary	vland 2088				
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	25. Wes case referred to medical axaminar?				28. Place of Dee	th (Check only one)					
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at fire death. I Director: After the din by the funeral Certification:	1 Neturel 5 Pending 2 Accident investigation 5 Suicide 6 Could not be 4 Homicide determined	28e. Pteca of Injury - At hor building, etc. (Specify)	ojo3 me, term, stre	AL 10	Yes 2 No	281. Location (Str. City or Town,	eet and Number or State) Kynto	Rurel Routa Number, 178 + A.F.C.				
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10(5)	11.1	0/ 1/10		0	C.M.E.		Novemb	er 1, 2000				
100	30. Nema and eddress of person who co		23a) (Type, F	Print)	ole In							
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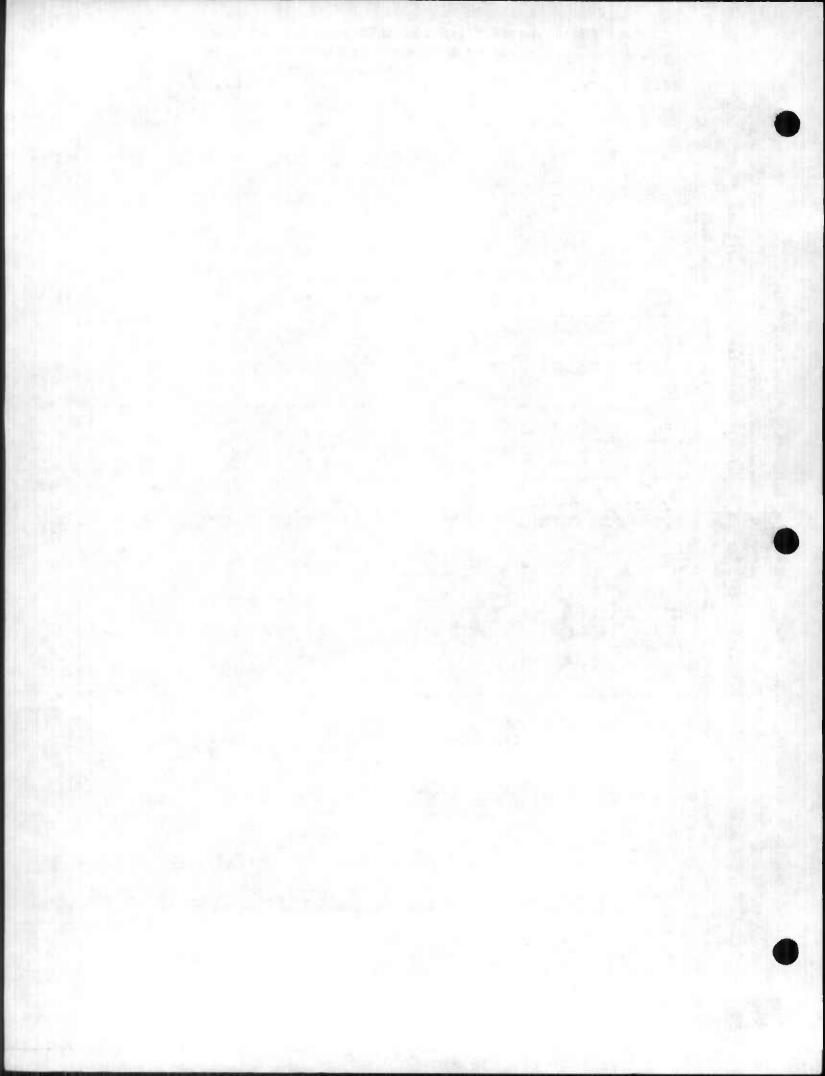


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State of Maryland / Department of Health and Mental Hygiene 1 3 7 1 7 9

						-	tificate		Death		Reg. No.		1013
	Physicia	an	Decedent's Nama (First, Middle)							2. Deta of Dec Month		Yeer	3. Time of Death
V	/Medic	_	Robert Nagle B							Novembe	-)0	2:35 AM
	Examin	er	4e Facility Name (If not institution,						b. City, Town, or L				
			305 Lorraine D			a fairet da d	If Undar 1 Y	1	Rockville If Under 24 Hrs.		Montgo		
	Funeral Director		5. Social Security Number 219-36-9036 Usuel Residence of Decedent	6. Sex 7, Ag	ga (In yrs. les	Yrs.		ays	Hours Min.	8. Dete of Birt (Month, Det March 1	3, 1940 V	Vash	olace (Stete or Foreign ntry) ington, DC
	P		10a. Steta 10b. County		10c. City,	Town or Loc	ation					1	10d. Inside City Limits
	Nery T	ō	Maryland Montg	omerv		Rockv	ille						1⊠Yes 2□No
	28	9	10e. Street and Number				10f. Zip Co	de	PARTY.		10g. Citizan of WI	hat Cou	ntry?
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	me 2	Jer	11. Mental Status	12. Wes Decedent		13. W	as Decedent	of Hi	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yas or No-	14. Race		can Indian,
_	or fe	by Fur	1 ☐ Never Merried 2 ☑ Merrie 3 ☐ Widowad 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Yaar or Datas:			Yes, specify Yas 2X			Rican, etc.)	Specify:	, White,	etc. hite
Maryland 21215-0020	natural',	8	15, Decedent'	s Education		16a. Decede	ent's Usuel O	ccupe	ation		16b. Kind of Bus	iness/In	dustry
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2	filed within Hygiene. other than	E	Cionientery/Secondary (0-12)	4	34)	Elec	tricia	n			Constru	cti	on
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<u>a</u>	should be nd Mental marked o	To	William L. Bea	ch					Eileer	n Dugan			
a			19a. Informent's Neme/Reletionsh	ip (Type, Print)					and Number or Ru				
	27 P		Maugherita Zima	Beach/Wife		305 L	orrain	e l	Drive, Ro	ckville	, Maryla	ind :	20852
5	5 Z Z		20e. Method of Disposition 1 ☐ Buriel 2 ☼ Cremetion 4 ☐ Donation 5 ☐ Other (Sp		cem	netery, crem	ition (Neme of etory or other Cremato:	r pleo	_ 11/	ov. 7, 2000	Bethesda		
	permit. Page Department of Important: If eny Injury or page.		21. Signature of Funeral Service L		120110	, ,							
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F	hysician		23a. Pert1. Entar the disaase, or o shock, or heart failure. List o	complications that cause only one cause on aach li	d the deeth. ine.	Do not ente	r the mode of	f dyin	g, such es cardiac	or raspiretory er	rest,	1	Approximata Intervel Between Onset and Death
	/Medical		Immediate Ceuse (Finel disease or condition	Lung	Cancer								14 months
E	Examiner		resulting in deeth)	a	Due to (or e	-	uence of):						
	n =	ner											
oʻ	fileste be executed physicien end is the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Ь.	Due to (or e	s e consequ	ence of):				14.34		145.5
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	the e	/sic	Pert II. Other aignificant condition	e contributing to death b	out not rasulti	ng in tha un	derlying caus	e give	en in Pert I.	23b. Did 1	obacco use conf	tribute t	to the cause of death?
7	vequires mat me de been signed by the should be detached									10	Yes 2 No	3 Pro	bably 4⊠ Unknown
Š	signe 1 be d	by			9							045.14	fore automorphic diago
0	neen houk	etec									en autopsy med?	9/	Vere autopsy findings vailable prior to completion of cause
e i	has b	Completed									v	of	deeth?
= 5	cate ha									101	as 2 No	1	☐ Yes 2☐ No
Vital	yaician: Indiana is certificate director, pag	Be	25. Wes case referred to medical axaminer?	Monitol				Oth	26. Plece of Dee	th (Check only o	ne)		
0	this dir	2	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospitel: 1 Inpatie	2	2/Outpatient		Othe	4 U Nursing H		lence 6 Othe		fy)
ב	eath. lor: After the funer	0	1 Neturel 5 ☐ Pending		y Year)	8b. Time of Injury	M 28c.	Work	yat k? Yes 2 □ No	28d. Describe i	now injury occurre	ю	
S		cat	2 Accident investige 3 Suicida 6 Could n	ot be	ium. As ham	. (195 2 1140	28f Location (Street and Numbe	ror Dur	rel Route Number,
	after death after death Director: d in by the	Certification:	4 Homicide determin	28e. Plece of In	ic. (Specify)	e, rarm, stre	et, rectory, or	nice	211	City or Tov	m, State)	i or mor	or mobile realition,
	Pura Pura Pura Pura Pura Pura Pura Pura	0	29a, Certifier 1/X Certifying	Physician: To the best	of my knowle	adaa daath	annumed at the	ha tim	o data and place	and due to the	sauco(s) and man	20.100	rtetod
	within 24 hours after or At To the Funeral Direct completely filled in by	edical	(Check only 2 Medical E	xaminer: On the basis o end menner st	f examinetion		estigetion, in	my of	plnion, deeth occur	rred et the time,	dete and plece, a	nd due t	to the cause(s)
	within 2 To the	Σ	29b. Signature and title of certifiar	11/1	.1	10			e number		29d. Deta signed	(Month.	Dey, Year)
	10		Tough!	1. Hagge	very.	M	- D	32	407		November	7,	2000
			30. Name and address of person was Joseph M. Hagge:					er	Drive, #	300, Ro	ckville,	MD	20850
	Sta Registra		31. Date filed (Month, Day, Year)	32. Ragistr	rer's Signatur		Sport				100		
			1101	1		10.	hand a soul	-					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: #23A PART I FER HY State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM: #23 PART I, PER PHY G789 11-22-00 WR. 1. Decedent's Nema (First, Middla, Last) 2. Deta of Death Day Month **Physician** Year Allen 8, Bussler July 2000 Leroy 9:13 a.m. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Data of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months 12 M 2 F Yrs 215-16-1282 78 April 28,1922 Maryland Director Usual Rasidance of Dacedent 10b. County 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Directo Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1361 Gregg Drive 20657 United States Funeral 12. Was Decedent Ever in U,S Armed Forcas? 1044 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No 1944 If Yas, Give Yaar or Dates: 1964 1 Nevar Married 2 Married 1 Yas 2 No Specify: SpecifyWhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) <u>Electrician</u> Electrical Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Mental Mental Martin Bussler Mary M. Evans 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Shonne N. Farrell / Daughter 1361 Gregg Drive, Lusby, Maryland 20657 20b. Place of Disposition (Nama of 20e. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (realize of Crematory or other place)
Crematory permit. Pages Department of P Important. If the arry Injury or of 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 7-11-00 Charlotte Hall, MD Brinsfield-Echols 21. Signature of Funeral Service Lice 22. Nama and Addrass of Facility Brinsfield Funeral Home, P.A. M01114 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part f. En at the crease, or complications that it used the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hard failure. List only one cause of much line. Approximata Interval Between Onset and Death **Physician** Immediata Ceusa (Final diseasa or condition rasulting in death) /Medical MULTIPLE ORGAN SYSTEM **Examiner** Due to (or as a consequence of): CEREBROVASCULAR ACCIDENT **UROSEPSIS** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): CORONARY ARIERY DISEASE Physician/Medical Dua to (or as a consequence of): CONGESTIVE HEART FAITURE Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? CERCOPROVASCULAR BECIDENT, CORONARY ARTERLY 1 Yee 2 No 3 Probably 4 Unknown á DSEASE, CONGESTIVE HEART FAILURE 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy CHRONIC OBSTRUCTIVE PULMONING DISERSE PENK INSUFFICIONSY SETZURE

SUBDICION JEWATOMA TROSERSE

25. Was casa referred to medical axaminar?

1 Yas 20 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 1 Yes 2 No 1 Yas 2 No of Vital Attending Physician: 26. Placa of Deeth (Check only ona) Other: Wursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Panding or Attending after death. Director: Aft 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 2 4 Homicida within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner steted. 29a. Cartifier Medical To the 29b Signatura and titla of certifier 29d. Data signed (Month, Day, Year) 29c. License number

State Registrar 31. Data filed (Month, Day, Year)

JUL 1 4 2000

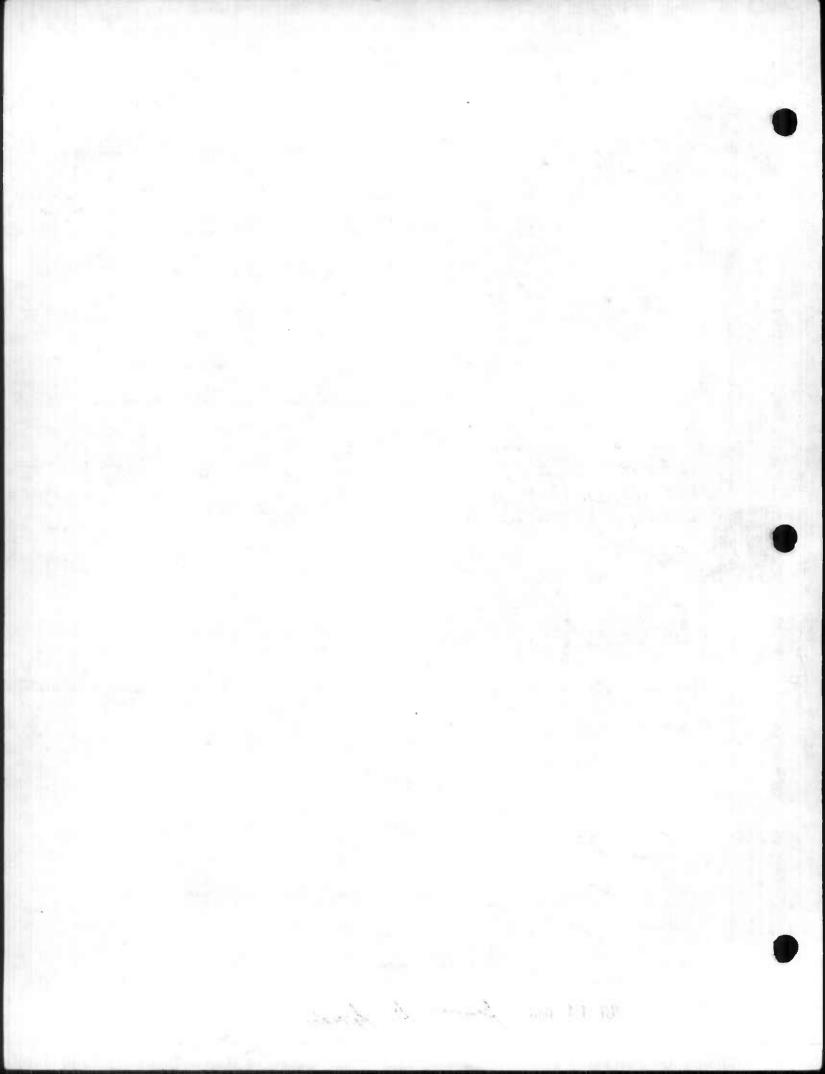
CHVH 29499 CHARLOTTE HACE RD., CHARLOTTE HALL, NAD 20622 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

of fullan

30 Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

getura G. Soo

D50963



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Dey Year November 6, 2000 Ruth Elizabeth Carter 1445 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 10 M 20 F Months Days Hours 218-26-2285 75 Yrs. Nov. 25, 1924 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21901 22 Roosevelt Avenue U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 11. Merital Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Aberdeen Proving Ground College (1-4or 5+) Two Years Elementery/Secondary (0-12) Aberdeen, Maryland Librarian 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Edna Brown Lee B. Janney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles E. Carter (son) 706 Giles Street, Havre de Grace, Maryland 21078 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removel from State 11/11/00 Havre de Grace, Maryland Angel Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Lee A. Patterson & Son Funeral Home, P.A. Honor II. totterson 21903-0766 Perryville, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): 0 heis Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events Due to (or es a consequença of) 20 fc ato d

Due to (or es e consequence of): resulting in death) Lest Wodge Lemi 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Directo

Funeral

þ

Completed

th and Mental Hygiene. 7 is marked other than "natural", or flema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natu any injury or other traumatic event, the traumatic event
death

72 hours after

Maryland 21215-0020

Baltimore,

/Medical

attending physician and for use as the burial-transit

Physician/Medical Examin þ Completed this certificate has Be P

Certification: death.

68760. Box P.0. Olvision of Vital Records, Director: After thi filled in by within 24 hours a edical

Ruth

State Registrar

29b. Signeture end title of certifier

Hospital:

5 Pending investigation

6 Could not be determined

29c. License number 20215

28c. Injury et Work?

1 Yes 2 No

26. Plece of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 11, Denwind C7, Gleman mo 21057

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of Injury

31. Date filed (Month, Day, Year) NOV 13 2000

25. Was case referred to medical examiner?

1 Yes 2 No

27. Menner of Death

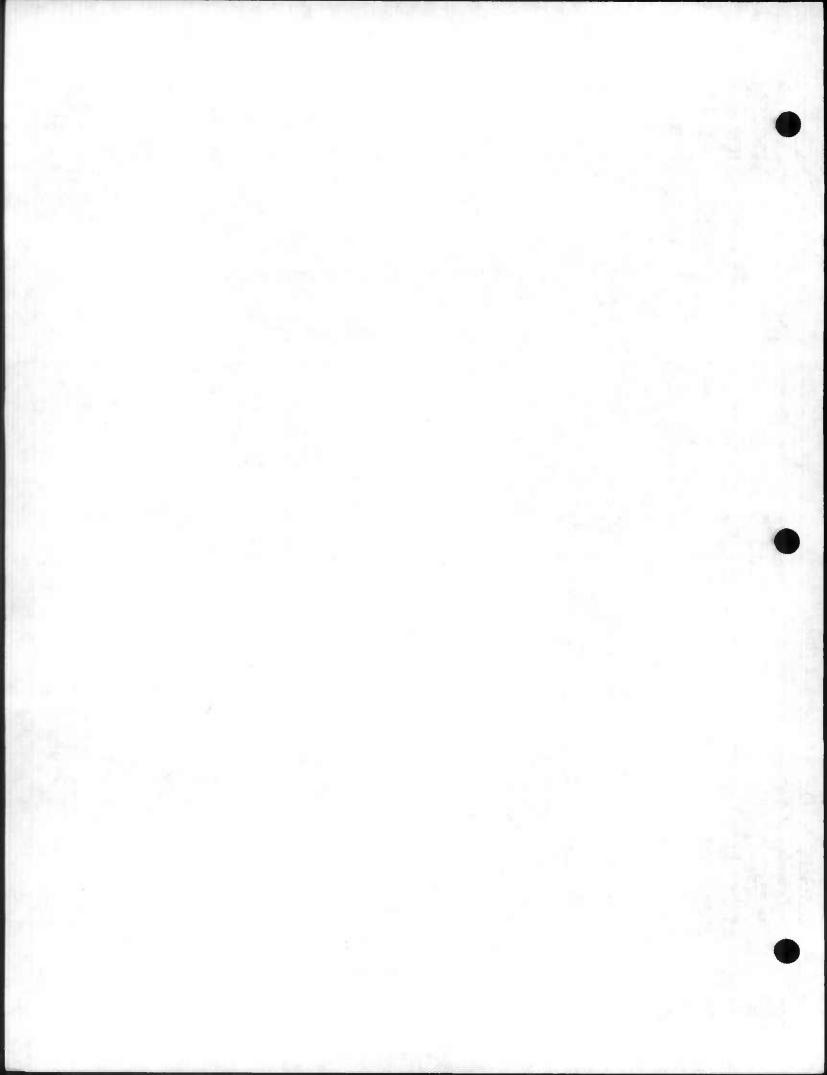
1 Naturel 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

32. Registrar's Signature



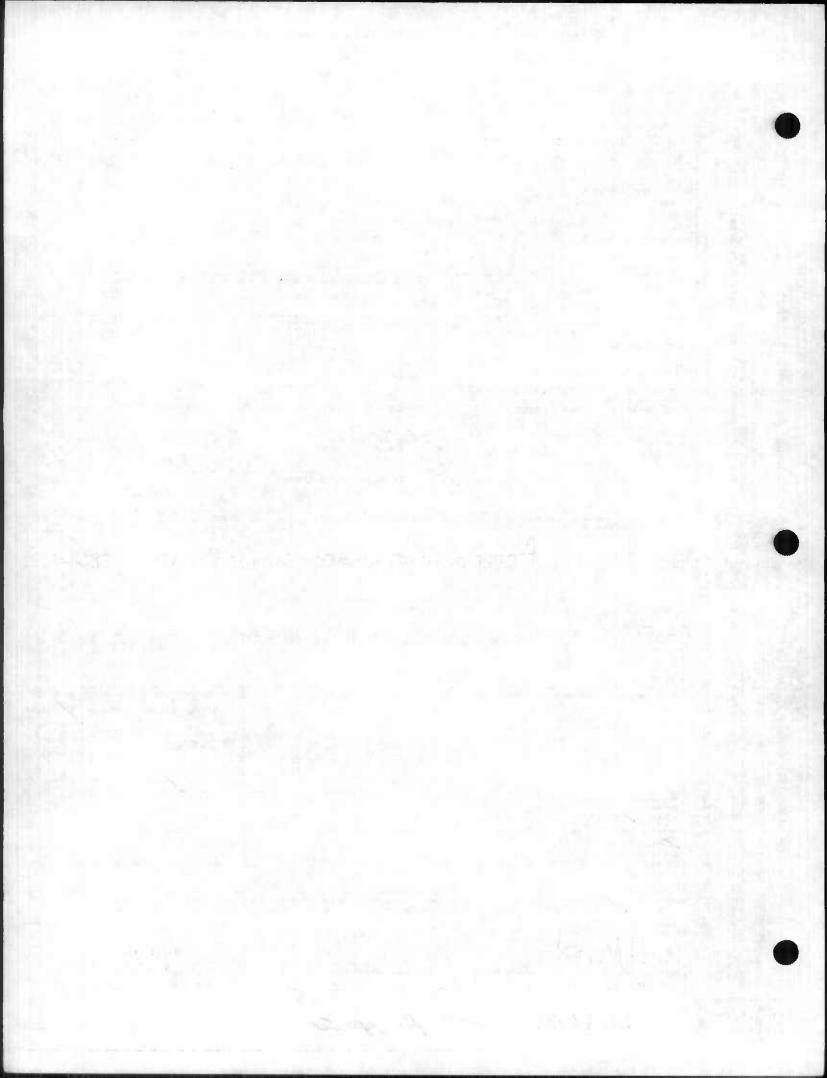
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			Ce	rtificate of	Death		Reg. No.					
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Physician	CHRISTINE	HOLLAND	CA	THELL		NOV.	Day 5	2000	7:50 AM			
/Medical Examiner	4e Facility Neme (If not Institution,		OA		4b. City, Tow	n, or Location of E		ounty of Death	7.30 AII			
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Director	Usual Residence of Decedent		00			DEC.	19, 191	. J HA	KILAND			
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Assy Mary Mary	MARYLAND WICO	MTCO	DIMMON	TIID					1 ☐ Yes 2 🛣 No			
or 28e-f s be notified	MARYLAND WICO	MICO	PITTSV	10f. Zip Code			I too Citizo	n of What Cour	oto 2			
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ath number of party and pa	4720 TIMMONS			218				USA	4 8			
ther death with the Maryla r hams 23a or 23e-f shor sher must be notified at furneral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U,S. 13.	Was Decedent of his Yes, specify Cub.	fispanic Origi an, Mexican,	in? (Specify Yes o Puerto Rican, etc.) 14	. Race - Americ Black, White,				
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Francis de by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:						, MU	ITE			
of diga	t5. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occup kind of work done	ation during most	of working	16b. Kind	of Business/In	dustry			
ed within 72 ho vgiene. er then 'neturn t, the Medical. Completed	Elementery/Secondary (0-12)	College (t-4or 5+)	life.	kind of work done DO NOT use retire	0)							
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Be every	17. Father's Name (First, Middle, La	ast)			t 8. Mother	's Name (First, Mic	ddle, Meiden St	ımamə)				
marked marked amarke	JOHN K.	HOLLA	ND		MAI	RGIE	LEWIS	3				
PEE	t9a. Informant's Name/Relationshi	p (Type, Print)	19b. Maili	ing Address (Street	and Number	or Rural Route No	umber, City or 1	own, Stete, Zip	Code)			
ang z eath a er tra	CHARLES L. CAT	HELL/SON	8631	WINTERGR	EEN PI	ACE. DEL	MAR. MD	21875				
-116	20a. Method of Disposition		20b. Plece of Disp			Date		ition - City or To	own, State			
rages rent of ret: If the	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe					111/0/0	O PTCHO	DWIII	MADS/T AST			
Apportant Ingentian Ing. Injury Injur		- 4		VILLE CEM			O BISHO	PVILLE,	MARYLAND			
May 1	21. Signature of Funeral Service Location 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE											
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al Director: After ted in by the funeral Certification:	4 Homicide determin	ed 28e. Place of Injury building, etc. (S	 At home, farm, st Specify) 	reet, factory, office			on (Street and in Town, State)	Number or Run	al Route Number,			
S e d												
Funeral funeral filed filed	29a. Certifier Certifying	Physician: To the best of m	y knowledge, deat	h occurred at the til	me, date and	place, and due to	the cause(s) ar	nd manner as s	stated.			
within 24 hours after death. To the Funeral Director: After completely filled in by the funer medical Certification:	one) 2 Medical Ex	amfner: On the basis of exe end manner stated		түөэндөноп, иг ту с	printon, deeth	occurred at the ti	ine, uete and p	ace, sno oue t	o are cause(s)			
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2 mar	20 Name and address of any	OVE MO	(Itam COs) (To	Deint)			1	5,00				
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State of Maryland / Department of Health and Mental Hygiene 00 37083

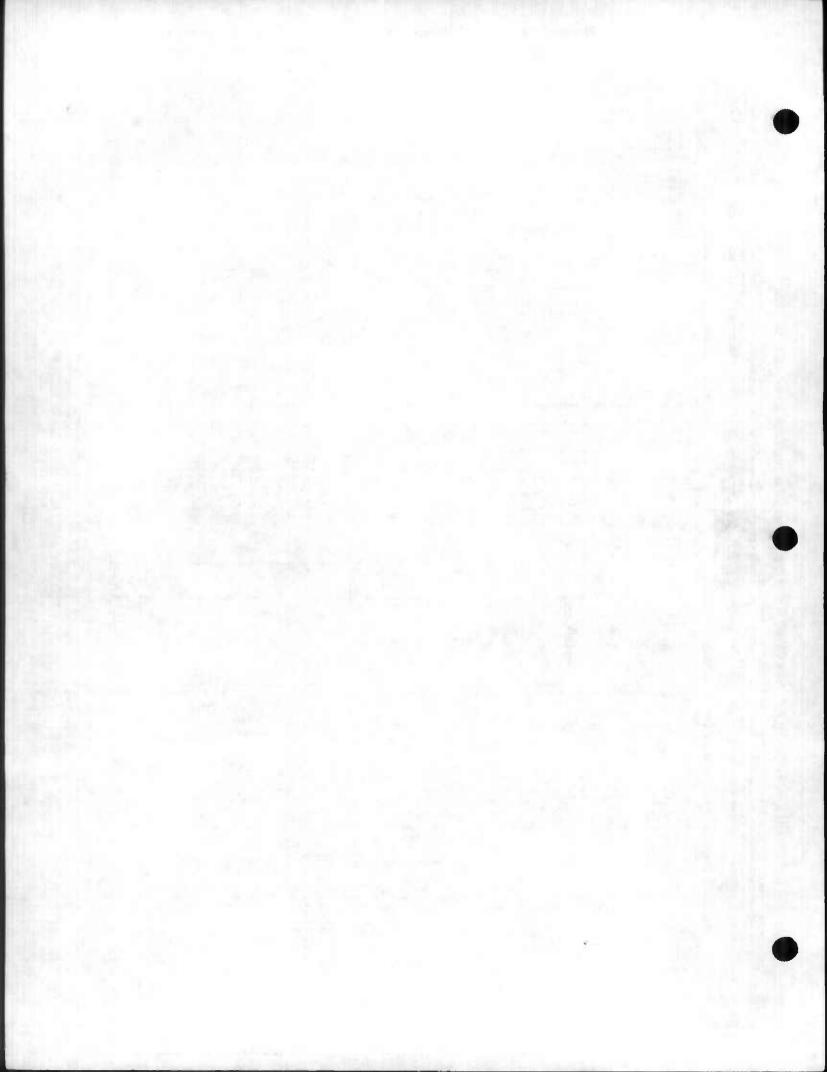
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Physician /Medical	Immediate Cause (Final		1-1-	-1-2	1	C		1 4			10.
Examiner	diseese or condition resulting in death)	е	Hell				DO VA	irnlar O	sase		Tehrs
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ansit min		b	Di	10 to /or oc o o	onsequence of	1).				1	
exec in an ial-tr	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury			20 10 (0) 03 0 0	O I SOQUOI ICO OI						
ficate be executed sphysician and state burial-transit edical Examiner	thet initieted events	c	Du	ie to (or es e c	onsequence of):					
2 2 2	resulting in death) Last	d									
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en sig										CC	mpletion of cause
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The law requirente has been signage 2 should be completed to						W.			Yes 20 No		death? ⊒Yes 2□No
ran: The law requires that the death ce difficate has been signed by the attendi ctor, page 2 should be detached for use 3e Completed by Physician/	25. Wes case referred to me	dical					26. Place of I		Yes 20 No		death?
ystclan: The lav s certificate has director, page 2 fo Be Comp	25. Wes case referred to meexeminer? 1 □ Yes 2 ☑ No	dical Hosp	itel: 1 □ Inpatient	2 ER/Out	patient 3 (DOA O	hor	1 🗆	Yes 2 No	1	death? ☐ Yes 2☐ No
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cei	rtificat	e of L	Death		Reg. No	, 01	0 3	1084
Street at an	1. Decedent's Na	me (First, Middle, L	ASI)	. (2)					2. Date of Month	Death Da	v	Year	3. Tima of Death
Physician /Medical		arie Codo	lington ive street and number)			4	b. City, Town,	Novemor Location of De	ber 3	3, 20 County of	00	1:55AM_
Examiner		oss Hospi	William Indiana					ilver				omery	
Funeral	5. Social Security		Sex 7. A	ge (In yrs. I	ast birthday)		1 Yeer	If Under 24	Hra. 8. Date of	Birth Dey, Year)			ce (State or Forei
Director	216-40- Usual Residence		1□M 2√2F	57	Yrs.	Months	Days	noula i		14,19			ngton,D.
ring 23a or 28a-f show critical be notified at neral Director	10a. State	10b. County		10c. City	, Town or Lo							100	d. Inside City Limit
or 26s-fr be notifie Directo	Maryland 10e. Street and N		omery		Wheat		Cada			10- C	timen of Mi	hat Countr	2
Die Die						10f. Zij						mat Countr	y r
matteral	12418 Co	nnecticut	12. Wes Deceden	Ever in U.S	3. 13.		20906 dent of H		(Specify Yes or		ISA 14. Race	- America	n Indian,
ramine by Fu	1 Never Ma	rried 2 Married 4 Divorced	Armed Forces	?		If Yes, spe		n, Mexican, P Specify:	? (Specify Yes or uerto Rican, etc.)		Specify:	white, et	
acal dead	10-	15. Decedent's I	Education		16a. Dece	dent's Usu	al Occup	ation	undina	16b. k		siness/Indu	
ygiene. er then 'neturn t, the Medical Completed	Elementery/Sec	ecify only highest g condary (0-12)	College (1-4or	5+)	Homem		se retired	during most of	working	Over	Hom	0	
	17. Father's Name	e (First, Middle, Las	st)		пошеш	aker		18. Mother's	Name (First, Mid				
Mental F subset off affic ever To Be								111	D				
		Smith Name/Relationship	(Type, Print)	-	19b. Maili	ng Addres	S (Street	Hazel en <i>d Number o</i>	POOI r Rural Route Nu	mber, City	or Town,	State, Zip C	Code)
or traup		Stearns	(son)	17 G1	enead	les	Drive	Newport	Beac	h.Ca	lifor	92660
110	20e, Method of D	isposition		20b. PI	ece of Dispo	sition (Ne	me of		Date			City or Tow	
ry or o		2 ☐ Cremation 3 5 ☐ Other (Spec	☐Removal from State cifv)						11/6/00	Rock	37 f 1 1 d	a Mar	v1and
order Inju		Funeral Service Lic		ITAL	22	2. Name a	nd Addres	ss of Facility					yland
OF SE	1 54	Our Co	V						s Funera				m 20001
	23a. Part1. Enter	r the disease, or co	mplications that ceuse by one cause on each	d the death					vd.,W.,S		Spr		Approximate Interval Between
Medical xaminer	Immediate Cause disease or condit resulting in death	tion	a Intrac		L Hemo								
physician and s the burial-transit	Sequentially list of any, leading to cause. Enter Uncause (Disease that initiated ever	conditions, immediate derlying or injury	c		as a consec			J. N.				1	
0.4	resulting in death) Last	f d	Due to (or	es e consec	quence or):							
e attendir ad for use siclar/A	Part II. Other stor	nificant conditions	contributing to death	out not resu	lting in the u	inderlying	ause div	en in Part I.	23b. t	Did tobacc	o use con	tribute to	the cause of deal
by th									1	I □ Yes	2≅ No	3 Prob	ably 4 ☐ Unkno
been sign should be				-						Vas an auto erformed?	opsy	avai	re autopsy finding lable prior to apletion of cause eath?
page 2									1	☐ Yes 2	DI No	10	Yes 2□ No
certificate rector, pag Be Co	25. Wes case refe	erred to medical						26. Place of	Death (Check or	nly one)			
P () (1)	examiner?	No No	Hospital: 1 Inpat	ient 2 🗆 l	ER/Outpatie	nt 3 D	Oth Oth	er: 4 Nursi	ng Home 5 🗆 F	Residence	6 Othe	er (Specify)	
		ath	28a. Date of Inj (Month, D	ury ay Year)	28b. Time o Injury	M	28c. Injur Wor 1 🗆	yat k? Yea 2 □ No	28d. Descr	ibe how inju	ury occurr	ed	
E E	27. Menner of De 1 X Natural 2 Accident	5 Pending investigati											
to: After this the funeral dication: To	1 X Natural	5 Pending investigati	be 28e. Place of Ir	ijury - At ho tc. (Specify		reet, factor	y, office		28f. Location	on (Street a Town, Stel	nd Numbe	er or Rurel	Route Number,
tor: After this the funeral di	1 X Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending investigating 6 Could not determine	be 28e. Place of Ir	of my know	vledge, deatl	h occurred	at the tin		City or lace, and due to	Town, Ster	e) s) end me	nner as sta	ited.
in 24 hours after death. No Funeral Director: After this pletely filled in by the funeral diffication: To edical Certification: To	1 3 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only	5 Pending investigati 6 Could not determine 1 Certifying P 2 Medical Exc	be d 28e. Place of Ir building, e 28e. Place	of my know	vledge, deatl	h occurred	at the tin		City or lace, and due to	the ceuse(: me, date an	s) end me	nner as sta	nted. the cause(s)
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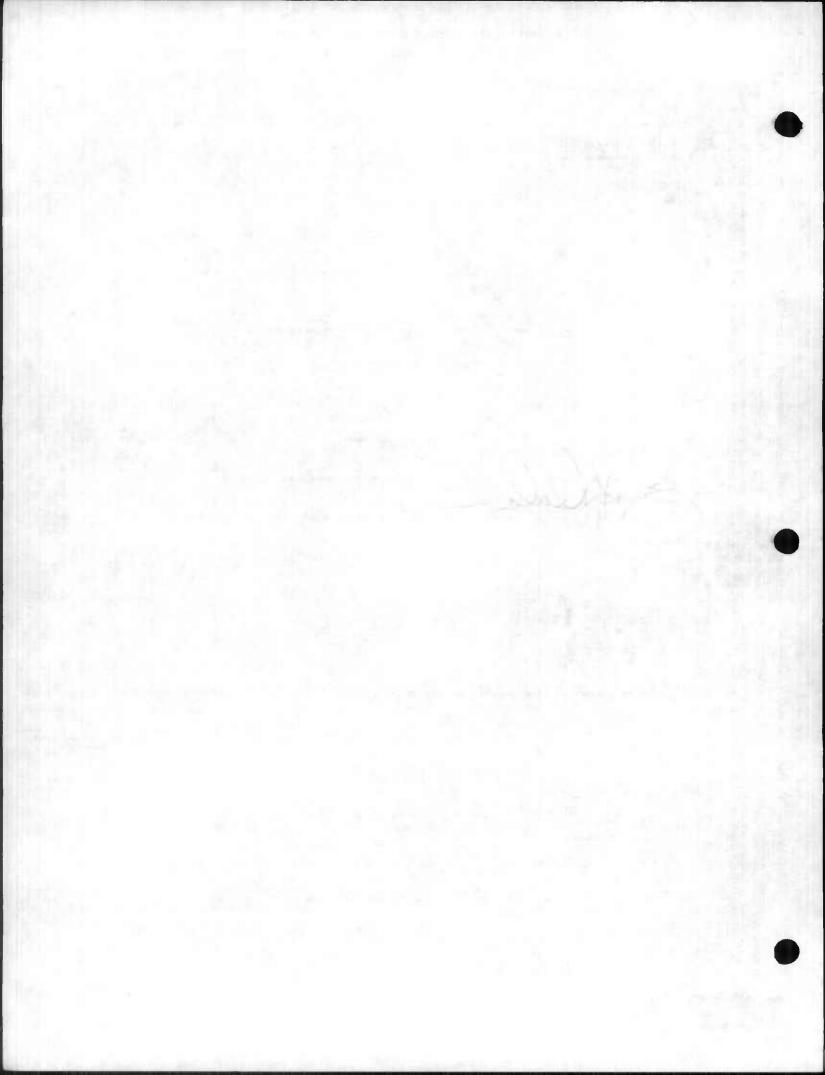
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 0 8 5

						C	ertifica	ate of	Death		Reg.	No.		00	
		1. Decedent's Nan	ne (First, Middla, Li	est)						2. Date of Month		Dey	Yaer	3. Tima of	Death
Physic /Medi		Say	V.	Chi						Nov.	4,	2000		:36	p.m
Exami			(If not institution, gi						4b. City, Town	, or Location of D	eath	4c. County			
		SHADY	GROVE A	ADVENTI	ST HO	SPIT				/ILLE		MON	TGOM		100
Funeral Director		5. Social Security I 214-23-	3330	32	Age (In yrs	. last birthd Yrs	Month	der 1 Yaa ns Deys		Hrs. 8. Date of (Month)	Birth Day Yes	1924	9. Birthplace Country) Viet	nam	r Foreign
2		Usual Residence of	10b. County		10c. C	ity, Town o	r Location						t0d.	inside Cit	v Limits
f sho	6	MD	Montgo	moru										1 Yes	
the the	Directo	10e. Street and Nu		шегу	Da.	rnest		Zip Code			10a.	Citizen of V	Vhet Country	7	
h with 23s or at he	73354		ones La	ne				878				S.A.			
uns after death with the Maryla af, or Herre 23s or 28s-f show Examiner must be notified at	by Funeral		ried 2 Married	12. Wes Deced Armed Force 1 Yes 2 If Yes, Giva Year or Det	es? No	U,S.	if Yes, s	pecify Cu	Hispanic Orlgin can, Mexicen, F Specify:	? (Specify Yas or Puerto Ricen, etc.)	No-	Blac	e - Americen k, White, etc		
72 ho natur Scal	Completed	/Sne	15. Decedent's E	ducation		16a. De	cedent's U	suel Occu	pation during most o	f working	16b	Kind of Bu	siness/Indus	try	
W	npie	Elementery/Sec		College (1-4	lor 5+)	1			ed)	Working		etna			
A STORY	Con		0			Mili	tary	7	1			vern			
ST S	88		(First, Middla, Las	1)					18. Mother's	Name (First, Mic	idle, Maio	len Sumam	(0)		
Men	2	Phoc C.				1			Sy Ni						
and 2 sh selft and n 27 is m ser traum		19a. Informant's N Peter H	. Chi	(Type, Print) Son		156	17 J	ones	t and Number of Lane	, Darne	sto	wn, I	State, Zip Co MD 20	878	
ermit. Pages 1 a Nepartment of He moortant: If Nem my Injury or other files.			position Cramation 5 Other (Speci		ate Na	Plece of Di cemetery, ation	rematory of	emo:		Data 11/8	Fal	ls C	City or Town	1, V	
permit. Pag Department Important: any Injury o	_	21. Signature of P	timenal Service Lice	nsee		I.	latio Fall	and Add naI	Funer urch.	al Home	7	482	Lee H	ighw	ay
Physician /Medical	(the disease, or con alt failure. List only	plications that ceur one cause on each	used the dea th line.	ith. Do not	enter the m	node of dy	ing, such es ca	rdiac or respireto	ry errest,		ln:	oproximate terval Bety nset and D	veen
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physician and the burial-transit	Exa	Sequentially list of any, leading to it cause. Enter Und Cause (Disease of	mmediate erlying	Due to (or es e consequence of): Acute renal Failure									5	days	
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eath certifica attending phi for use as th	5	rasulting in death)	Last	d. Esop					eedin	g			5	days	
death e atte	Icla	Part II. Other signi	ficant conditions	contributing to dea	th but not re	sulting in th	e underlyin	n ceuse c	iven in Part I	23b.	Did tobac	CO USE CO	ntribute to th	e cause o	of death?
ras that the de signed by the a be detached i	by Physician/		tension					,				2€ No	3 Probab		
aw requi	Completed b	Diabe	tes Mel	litus				¥			Ves en eu erformed		24b. Were availa comp of dea	ble prior to letion of co	0
9 2 8	Con									1	Yes	2 € No	1 🗆 Y	as 2	No
Iclan: The	Be	25. Was case refe examiner?	rred to medicel						26. Plece o	f Deeth (Check or	nly one)				
di di	2	1 ☐ Yas 2 页	₹No	Hospitel: 1 🔀 Ing	patient 2[□ ER/Outpa	itient 3	DOA O	ther: 4 Nurs	ing Home 5□ F	Residence	6 □Oth	er (Specify)		
Attending Phir death. actor: After th by the funeral		27. Manner of Dea 1 Netural 2 Accident	th 5 Pending investigation	28a. Dete of (Month,	Injury Day Year)	28b. Tim Inju		28c. Inj W	ury at ork?] Yes 2 No	28d. Descr	ibe how l	njury occur	red		
tal or Attending Pt is after death. In Director: After the ed in by the funera	Certification:	3 Suicida 4 Homlcide	6 Could not be determined	289. PIECE 0	f Injury - At I I, etc. (Spec	home, farm	, street, fac	tory, office			on (Street Town, St		er or Rural R	oute Num	ber,
To the Hospital or At within 24 hours after of yo the Funeral Direct completaly filled in by	edicai	29a. Certifier (Check only one)	Certifying Pt	nysician: To the be miner: On the bas and manne	is of examin	owledge, dation end/o	eath occurr r investigat	ed et the ion, In my	ime, dete end popinion, death	plece, and due to occurred at the ti	the cause me, date	e(s) end ma end place,	end due to th	ed. e cause(s)
Within To the Comp	Ž	29b. Signatura and	titla of certifier			1 1/1		29c. Licer	sa number		100		d (Month, Da		
5		20 Name and said		(1.)	- 020) (7	- Br/- 1)	01	1729	5	No	vemb	41	200	00
		30. Name and add	ress of person who					0 0	ant /	Taitha-	ah	200	4D 201	77	
	- 10	31. Date filed (Mor			istrar's Sign		GIOV		uit,	Jar Cher	spu]	Ly, 1	עד ארד	0//	
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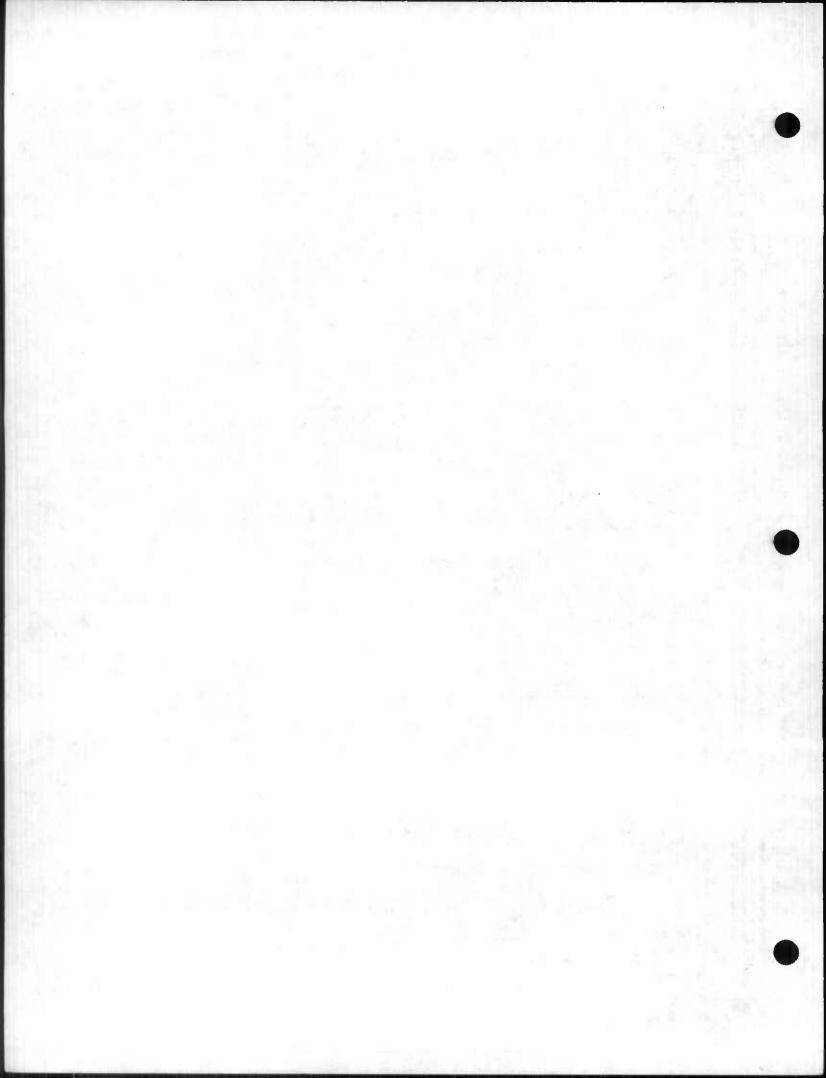
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene \(\cap \)

Dhani	1. Decedent's Neme (First, Middle, Las		3071	ificate of		2. Date of Dea		3. Time of Death	
Physician /Medical	Samuel C. Dix					ovember			•
Examiner	4a Facility Name (If not institution, give Union Hospital	street and number)		March 1	4b. City, Town, or Elkton		4c. County of Ceci	1	
Funeral Director	5. Social Security Number 2 18 – 34 – 8146 1 Usual Residence of Decedent	7. Aga (In yrs. M 2□ F 62	last birthday) Yrs.	If Undar 1 Yaar Months Days	If Under 24 Hrs. Hours Min	8. Date of Birth (Month, Day une 15	1938	9. Birthplaca (State or Foreign Country) Maryland	
or items 23a or 28a-f show miner must be notified at Funeral Director	10a. Sfate 10b. County Maryland Cecil		y, Town or Loca kton	ation	F 77	- 117	- 7	10d. Inside City Limits 1 ☐ Yes **ENo	
at be notified al Director	10e. Street and Number 205 West Pulas	ki Highway		10f. Zip Code 21921			U.S.A.	nat Country?	
9 6	11. Marital Status 1 Never Married 2 Married 3 Widowed MODivorced	12. Was Decedent Ever in U Armed Forces? **El Yas 2 No If Yes, Give Kore Yaar or Dates:	a 16	as Decedani of I Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	Black	- Amarican Indian, , Whita, atc. White	
r, the Medical Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decede (Give ki life. Do Physi	nt's Usual Occup ind of work done O NOT use retire Cal In	ventory	rking Counte	16b. Kind of Bus	n Company	
o Be C	17. Father's Name (First, Middle, Last) Herman Dixon					me (First, Middla, atherin			
1	19e. Informent's Name/Relationship (1 Mickey S. Dixo				and Number or Ru 835 New				
ry or othe	20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Specify	Removal from State		tion (Name of atory or other pla ris In	ce) C. 1I	Date /13/00		ter, Pa.	
any inju	21. Signature of Jumental Service License	9			ess of Facility Ge Main St				
	23a. Part1. Enter the disease, or comp shock, or heart railura. List only	hisations that causad the daar	th. Do not entar	the mode of dyi	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death	
sician edical miner	Immediate Cause (Final disaese or condition resulting in deeth)	a. Carcine	me o	Luc	9		- 3	IM	
i e		COPD	or as a consequ	enca of):	1			5 yers	
the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	D	or as a conseque	enca of):					
2	Cause (Disease or Injury that initiated events resulting in death) Last	c. Dua to (c	or as a conseque	anca of):					
eteched for use as Physician/Me	Part II. Other significant conditions of	ofributing to death but not rea	ulting in the unc	feriving cause di	ven in Part I.	23b. Did t	obacco use cont	ribute to the cause of death?	_
be deteched by Physic								3 ☐ Probably 4 ☐ Unknow	
should						24a. Was perfo	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?	
Pege 2	St. The Co.					101	es No	1 ☐ Yes 2 ☐ No	
Be	25. Wes case referred to medical examinar?	Hospital: _X			hor	ath (Check only o			
	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3L DOA 28c. Inju	4 Li Nursing F	dome 5 ☐ Resid	lenca 6 LOther	* * * * * * * * * * * * * * * * * * * *	_
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At h building, etc. (Specific	Injury ome, ferm, stree (y)	M 1	rk?]Yes 2□No	28f. Location (5 City or Ton	Street and Numbern, State)	r or Rural Route Number,	
pletely filled	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Example 1	raician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deeth outline	occurred at the ti	me, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) and man dete end plece, a	ner as steted. nd due to the cause(s)	
Mec Mec	29b. Signature and filla of certifier	and mainlet stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)	
IVA	I fui chil			Do	4823		11/14/6	00	
	30. Nama and addrass of person who o		n 23a) (Type, Pi	rint) lest m	vani st	- THIL	ton L	12 21921	
State	31. Dafa filed (Month, Day, Year)	32. Registrar's Sign							

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Menta	l Hygiene	3708
Certificate of Death	Reg. No.	

2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Month **Physician** 1445 3/ LAMBERT H DONOWAY OCTOLOGR 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Aga (In yrs. last birthday) | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | 8. Data of Birth | (Month, Dey, Yaar) Birthplaca (Stata or Foraign Country) 5. Social Security Number **Funeral** 66 217-28-2738 Director FEB. 13, 1934 MARYLAND Usual Rasidance of Decedant 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location 1 Yas 2 No Directo MARDELA SPRINGS MARYLAND WICOMICO 10f. Zip Coda 10g. Citizen of What Country? 10e, Street and Number 21837 U.S.A. 11491 TOWER HILL LANE Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Maritai Status 1 ☐ Yas 2 No If Yas, Giva 1 ☐ Nevar Married 2 🕅 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: WHITE 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) METAL COMPANY METAL WORKER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Surnama) and 2 should be setth and Mental WHITE FLORENCE DONOWAY CHARLES 19e. Informent's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) sartment of Health an portant: If item 27 is BARBARA DONOWAY - WIFE MARDELA SPRINGS, MD 21837 11491 TOWER HILL LANE 20b. Place of Disposition (Name of cematery, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) 11/3/00 SALISBURY, MARYLAND WICOMICO MEMORIAL PARK 21. Signature of Europa Barvice License 22. Nama end Addrass of Facility 705 E. MAIN ST. MD 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batwe Onsat end Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760, untosis Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 20 No 3 Probably 4 Unknown 2 of Vital Records, Completed by 24b. Ware autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 X No 1 ☐ Yas 2 No 1 🗆 Yas Hospital or Attanding Physician: Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Hospital: 12 Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Medical Certification: To 28c. Injury at Work? 27. Menner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Division 1 Natural 5 Pending after death. invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined To the Hospital or Atta within 24 hours after de To the Funeral Directo completaly filled in by th 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, deta and place, end due to the cause(s) and menner steted. 29a. Cartifiar

238

CHIN 31. Data filed (Month, Day, Yaar) State NOV 0 3 2000 Registrar

29b. Signature and title of commer

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Risersde 560 32. Pegistrar's Signatura

Salibung

29c. Licansa number

D005609

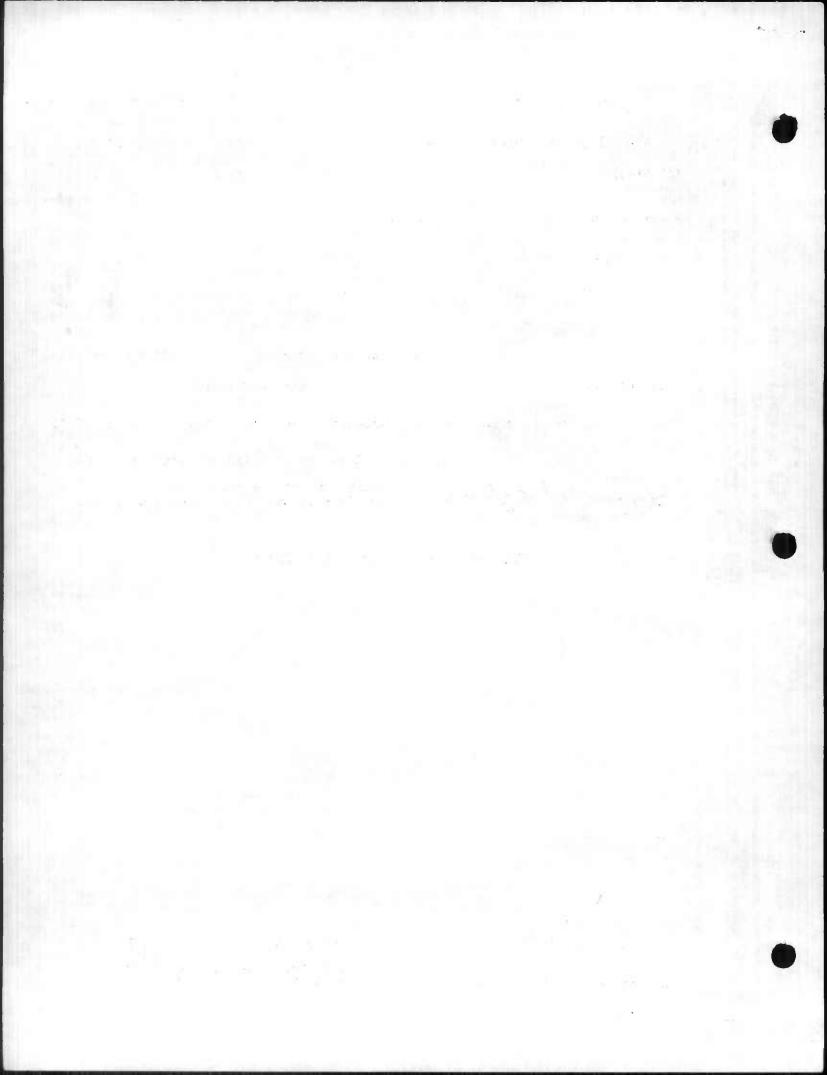
29d. Data signad (Month, Day, Year)

NOV 0 2 7991 Survey

State of Maryland / Department of Health and Mental Hygiene () ()

Certificate of Death

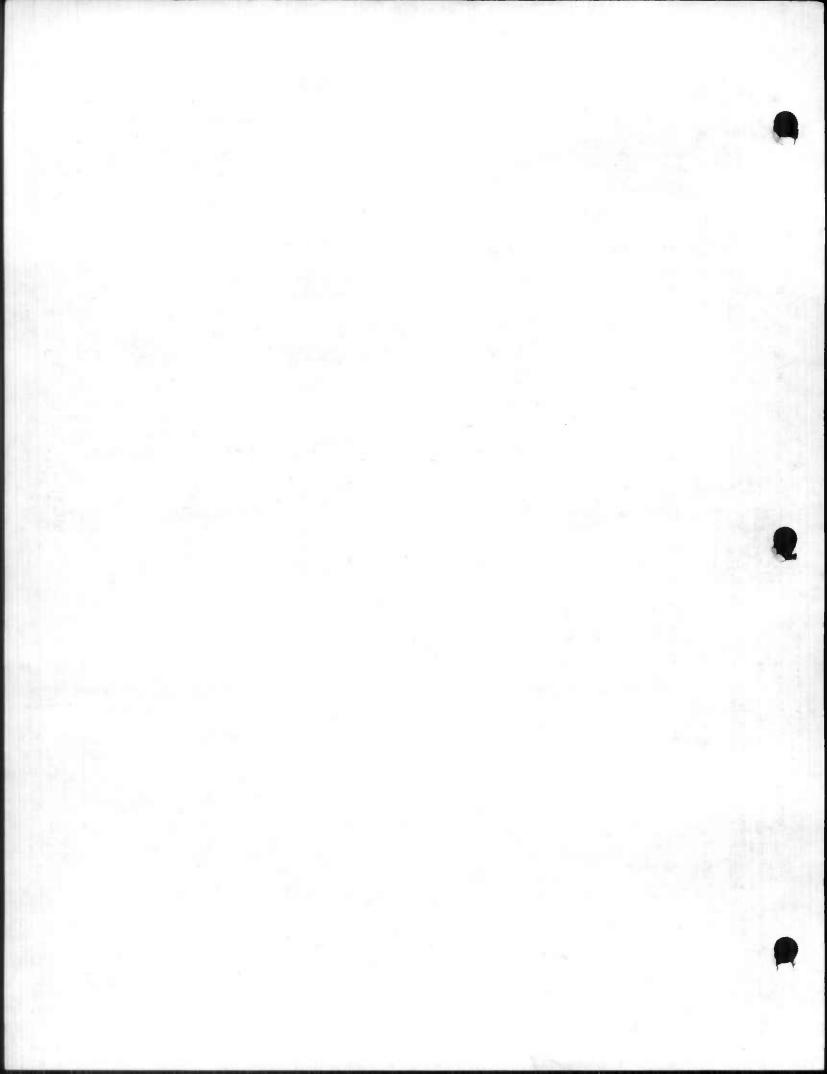
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Physicia /Medic	an ST			DAVIS				Month NO	V 1 Day 200	O Year	6:10 PM		
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Funeral Director	5. Social Security N 321-01-4	702	L MEDICA Sex 12 M 2 F		ER s. last birthday) Yrs.	If Under 1 Yes	ar If Under 2	Min. (Month,	Birth Day, Year) . 28,1910	9. Birthp Coun Ala	IERY lace (State or Foreign try) Lbama		
end	Usuel Residence of	10b. County		10c. (City, Town or Lo	ocation				1	0d. Inside City Limits		
the Maryler 28a-f ehow	Maryland	Montgo	merv	0	Chevy Ch	ase					1 No Yes 2 No		
or 28a	10e. Street and Nu		J			10f. Zip Code			10g. Citizen of	What Coun	try?		
th will	5610 Wi	sconsin	Avenue			2081	5		United	Stat	es		
5-0020 72 hours effer death with the Maryland natural:, or items 23s or 28s-f show steal Enatures must be notified a	Maryland 10e. Street and Nu 5610 Wi 11. Marital Status 1 Never Man 3 Widowed	ried 2/CXMarried	Armed Fo			Was Decedent of formation of the Yes, specify Control of the Yes 2 ☑ N		in? (Specify Yes or Puerto Rican, etc.)		ce - Americ ck, White, by: Bla	etc.		
21215-0020 d within 72 hours af giene. writhen "natural", or we have a few from the control of t	8	15. Decedent's		ales.1 94 Z		dent's Usual Occ	supation		16b. Kind of E	dustry			
within 72 ten.	(Specific Control of C	cify only highest g	rade completed) College (1	1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most (ired)	of working					
d 212 filed withi Hygiene. ther than out, the M	e community of		5	1 40.017	Exec	utive D			Trade Associa				
2 2 2 2	17. Fetner's Neme		st)						me (First, Middle, Meiden Surname)				
Maryland d 2 should be file the end Mental Hy. 7 is merked othe traumatic event.	e Edward		7 8 1 1						Galberth urel Route Number, City or Town, State, Zip Code)				
or Heal	19a. fnformant's N Christin 20a. Method of Dis N Burial 2	e Ray Da	vis, Wif	20b.	5610 Place of Disponentery, createry	Wiscons osition (Name of matory or other p	in Ave,	#503, C	nevy Chas	e, MD	20815		
Baltime permit. Peg Department important: if eny injury o		5 Other (Spec	**	R		ek Ceme		11/9/0	Washin	gton,	D.C.		
Baltin permit. Pe Department important: eny injury	21. Signature of Fi	uneral Service Lic	hy /	1 -	M		Funeral	Service					
	222 Part Entre	the disease or so	mplications that of	nucle the de	7 onth Do not on	400 Geo	rgia Av	e. N.W., cardiec or respirato	washingt	on, D	. C .		
Ox 68760, To certificate be executed and included as the buriel-transit use as the buriel-transit	fmmediate Cause disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter Under Cause (Disease or that initiated event resulting in death)	onditions, mmediate enving rinjury s	a. RUPT b	Due to	ORTIC A (or as a consector) (or as a consector) (or as a consector)	quence of):	L_ANEUR	YSM					
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P hat the d by detac	Part If. Other signi	nearit conditions	contributing to di	eam out not n	esciting in the o	ngenying cause	given in Perci.				bably 4 🖾 Unknowr		
O S S	Completed							24a. V	Vas an autopsy erformed?	av	ere autopsy findings ailable prior to mpletion of cause death?		
								1	TYYea 2□No	1[Yes 2∑ No		
of Vital Physician: The	25. Was case refe examiner?		Hospital:		¥		Ther:	of Death (Check or					
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Attending For death.	1 ⊠Naturel 2 □ Accident	5 Pending Investigati	(Mon	th, Day Year)	Injury	V	Vork? □Yes 2□N		,				
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Divisit To the Hospital or Attend within 24 hours efter deat To the Funeral Director: completely filled in by the	29a. Certifier (Check only one)		amfner: On the bi					f place, end due to h occurred at the ti					
To the within to the comp	29b. Signature and	nse number 1873 (N	(C)	29d. Date sign	ed (Month,	Day, Year)							
	30. Name and add	/ /	o completed caus				TIONAL THESDA	NAVAL MEI MD 20889	OICAL CEN	TER			
Sta Registra		nth, Dey, Year)	32.A	Registrar's Sig		Spork	w w						
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State of Maryland / Department of Health and Mental Hygiene

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			Certificat	e of L	Death		Reg. No.		01003		
	Decedent's Nema (First, Middle, Last)						Data of Death		3. Time of Death		
Physician	JANIES DEL TORO					NOV		2000 Yeer	11:50 PM		
/Medical Examiner	4a Facility Neme (If not institution, giv			41	b. City, Town	, or Location of I		County of Deet			
Cxamine	Laurel Regio			Laurel			D	PINCE	GEORGES		
Emand	5. Sociel Security Number 6. S		t birthday) If Unde	1 Year	If Under 24						
Funeral Director		1□M 287 59	Yrs. Months	Deys		Min. (Mont)	of Birth h, Day, Year)		hplace (State or Foreign		
Director	021-32-9863							0 00	nnecticut		
and and	10a. Stata 10b. County	10c. City, 7	Town or Location						10d. Inside City Limits		
Alany Or	MD Prince	Coo	Adelphi						N Yes 2 No		
he Me	MD Prince Geo. Adelphi						•				
72 hours after death with the Maryland natural, or items 23s or 28s-f ahow item Examiner must be notified at sted by Funeral Director	10e. Street and Number			10f. Zip Code				10g. Citizen of What Country? U.S.A.			
13a Iai	3120 Powder Mill Road 20783							U.S.A.			
r Herra 23a	11. Marital Stetus	12. Was Decedent Ever in U,S. 13. Was De If Yes, s			s Decedent of Hispanic Origin? (Specify Yas or Ness, specify Cuban, Mexican, Puerto Rican, etc.)			No- 14. Race - American Indien, Bleck, Whita, etc.			
or h	Never Merried 2☐ Merried	1 Yes No		1 ☐ Yes 2 ☑ No Specify:			Specify: White				
by	3 ☐ Widowed 4 ☐ Divorced	Yaar or Datas:	10 105								
ed within 72 hoyglene. or then "neturn", t. The Medical I	15. Decedent's Ed	ducetion	16a. Decedent's Usu	el Occupa	tion		16b. Kir	nd of Businass/	Industry		
within 7	(Specify only highest green Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)								
omp	Exemplifies y/Secondery (U-12)	l yr	Medical	Te	chnic	ian	He	alth S	ervices		
ETES 0	17. Father's Neme (First, Middle, Last,					Name (First, Mi			CIVICOD		
Mental H Mental H mrked ott	Peter G. De	1 Toro			Angel	ica In	ec Fi	engo			
should ind Men ind Men in market	19e. Informent's Neme/Reletionship (405 54 75 - 6 44	1					2. O. (1)		
0 0 0	and a committee control to the		19b. Mailing Addrass								
f Health frem 27 other tr	Sara L. Esco		1224 Je		Smit						
A PER P	20a. Method of Disposition 1 ☐ Burial 2 ②Crametion 3 ☐	000	e of Disposition (Na etery, cremetory or o		9)	Deta	20c. Lo	cation - City or	Town, State		
Pages nent of int: if its iry or o	4 Donetion 5 Other (Specif		ropolita	in F	/Srv.	11/8/	00 A	lexand	ria, VA		
2 8 2	21. Signature of Funeral Service Lices	ntae /	22. Nama er	d Addras	s of Fecility	1					
Departiment import on Injury	A tour L	(Augusto	SNO	WDE	N FUN	ERAL H	OME,	P.A.			
	- Eurya K	10 nowace	246	N.	Wash	. St.,	Rock	ville,	MD 20850		
	23a. Pert1. Entar the crease, or com shock, or haert failer. List only	plications that caused the death. one ceuse on each line.	Do not enter the mod	le of dying	, such es ca	rdiac or respirate	ory errest,	i	Approximeta Intarval Between		
Physician	Onset and Deeth										
/Medical	Immediate Cause (Final disease or condition Dullmonary Embolius 2 hours										
Examiner	diseasa or condition resulting in death) Pulmonary Embolus Due to (or es a consequence of):							2 hours			
<u> </u>			,					B			
asth certificate be executed ettending physician and for use as the burial-transit clan/Medical Examiner		b. — Due to /os o	s e consequence of):								
EX EX	Sequentially list conditions, if any, laading to immediate	Due to (or e.									
Dan Dun	ceuse. Enter Underlying Ceuse (Disaase or injury thet initiated events										
icate be physicians the bu	resulting In deeth) Last			į							
Jing Jing											
an or use	State of the State							1			
the etter the otter hed for u	Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.				23b.	23b. Did tobacco uss contribute to the cause of death?					
4 year							1 Yes 2 No 3 Probably				
5 00									robably 4 Unknow		
						24a.	performed? evailable prid		Were autopsy findings		
been s should									evailable prior to completion of cause		
law e 2 s e 2 s					_	of daath?					
The law requir							1 ☐ Yes 20	X No	1 ☐ Yes 2 ☐ No		
ysician: The lav s cartificate has director, page 2 fo Be Comp	25. Was casa referred to medical examinar?				26. Place of	Death (Check o	only ona)				
Physician: this cartific ral director, TO Be (1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 □ ER	VOutpatient 3□ DC	Othe	r: 4 🗆 Nursi	ing Homa 5	Residence 6	3 ☐ Other (Spe	city)		
Phys raid raid	27. Menner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?						ribe how Injury				
P 0 9											
ding in Alter funer funer		3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Routa Number, City or Town, State)			
ittending Ph death. ctor: After th y the funeral ifcation: "	3 Suicide 6 Could not be										
or Att	3 Suicide 6 Could not b										
or Att	3 Suicide 6 Could not be determined	building, etc. (Specify)									
or Att	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Specify) ystclan: To the best of my knowle	dge, deeth occurred	et the time	e, date end p	place, end due to	the cause(s)	end menner as	steted.		
or Att	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Specify)	dge, deeth occurred end/or investigation	et the time, in my op	e, date end p inion, deeth	place, end due to occurred at the t	the ceuse(s) ime, date end	end menner as plece, and dua	steted. to the cause(s)		
or Att	3 Suicide 4 Homicide 29e. Certifier (Check only 2 Medical Exam	building, etc. (Specify) yalclan: To the best of my knowle niner: On the basis of examinetion	end/or investigation	et the time, in my opi	inion, deeth	place, end due to occurred at the t	ime, date end	end menner as plece, and dua a signed (Mont	to the cause(s)		
To the Mospital or Attending To the Funers after death. To the Funerel Director: Afte completely filled in by the fune funeral completely filled in by the funeral completely filled in th	3 Suicide 4 Homicide 29e. Certifier (Check only one) Check only one) 6 Could not be determined	building, etc. (Specify) yalclan: To the best of my knowle niner: On the basis of examinetion	end/or investigation	, in my op	inion, deeth	place, end due to occurred at the t	ime, date end	plece, and dua	to the cause(s)		
or Att	3 Suicide 4 Homicide 29e. Certifier (Check only one) 29c. Segnature and little of cartifor	building, etc. (Specify) yalclan: To the best of my knowle niner: On the basis of examination end menner steted.	end/or investigation	, in my op	inion, deeth	place, end due to occurred at the t	ime, date end	plece, and dua	to the cause(s)		
or Att	3 Suicide 4 Homicide 29e. Certifier (Check only one) 29c. Separature and little of cartifor 30. Name and address of person who	building, etc. (Specify) yalclan: To the best of my knowle nlner: On the basis of examination and menner steted.	end/or investigation	, in my op	number	occurred at the t	29d. Dat	plece, and dual	to the cause(s)		
or Att	3 Suicide 4 Homicide 29e. Certifier (Check only one) 29c. Segnature and little of cartifor	building, etc. (Specify) yalclan: To the best of my knowle nlner: On the basis of examination and menner steted.	Ja) (Type, Print)	, in my op	number	place, end due to occurred at the t	29d. Dat	plece, and dual	to the cause(s)		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NEZ 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) WASHINGTON ADVENTIST Takoma Park Montgomery 8. Date of Birth (Month, Dev. Year) (Month, Dev. Year) (Country) Nov. 19, 1904 Arkansas If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 10 M 20 F Days Hours 577-60-2158 95 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No N/A Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4504 Argyle Terrace, N.W. 20011 United States 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 (A)No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black White etc. African 1 ☐ Nevar Marriad 2 ☐ Married 1 Yes 2 No Specify: Specify American 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Claims Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middla, Last) Howard Battles Sarah Spight

20b. Place of Disposition (Neme of cemetery, cremetory or other plece)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of)

Due to (or as e consequence of):

Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

N/A

19a. Informent's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licens

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in deeth)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury

that initiated events rasulting in death) Last

Dorothy L. Colbert-Blake / Niece

MENTIA

hompso

1 XBurial 2 Cremation 3 Removal from State

Director

Funeral

P

Completed

Funeral

Director

ltem 27 is marked other than "natural", or frems 23a or 28a-f show other traumatic event, the Medical Examiner must be rectified at

permit. Pages 1 end 2 should be filed within 72 hours after Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or frea any injury or other traumatic event

Baltimore, Maryland 21215-0020

with the Maryland

death

physician and s the burial-trans 98 950 Pol signed by t peed

Examiner

Physician/Medical

þ

Completed

Be

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Certification:

Medical

the death certificate be axecuted pege 2 certificata has After this funeral if or Attending P after death.

Division of Vital Records.

Hospital

Registrar

31. Data filed (Month, Day, Year) NOV 6 7 2000

29b. Signatura and titla of certifiar

25. Wes case referred to medical examiner?

1 Yes 2 No

5 Pending

investigation 6 Could not be determined

27. Menner of Deeth

1 Natural
2 Accident

3 Sulcide

(Check only one)

29e. Certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? 1 ☐ Yes 2 Z No 1 ☐ Yes 2 ☐ No 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner statad. 29d. Date signed (Month, Dav. Year) 29c. License number 2000 cryon and aurence 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lawrence Simon, M.D. 7600 Carroll Ave. Takoma Park, MD 20912 32. Registrar's Signeture

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)

Lincoln Memorial Cemetery11/10/00 Suitland, Maryland

7400 Georgia Ave. N.W., Washington, D.C.

(CARPINE Standstill

20c. Location - City or Town, Steta

23b. Did tobacco use contributa to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Approximete Interval Between Onset and Death

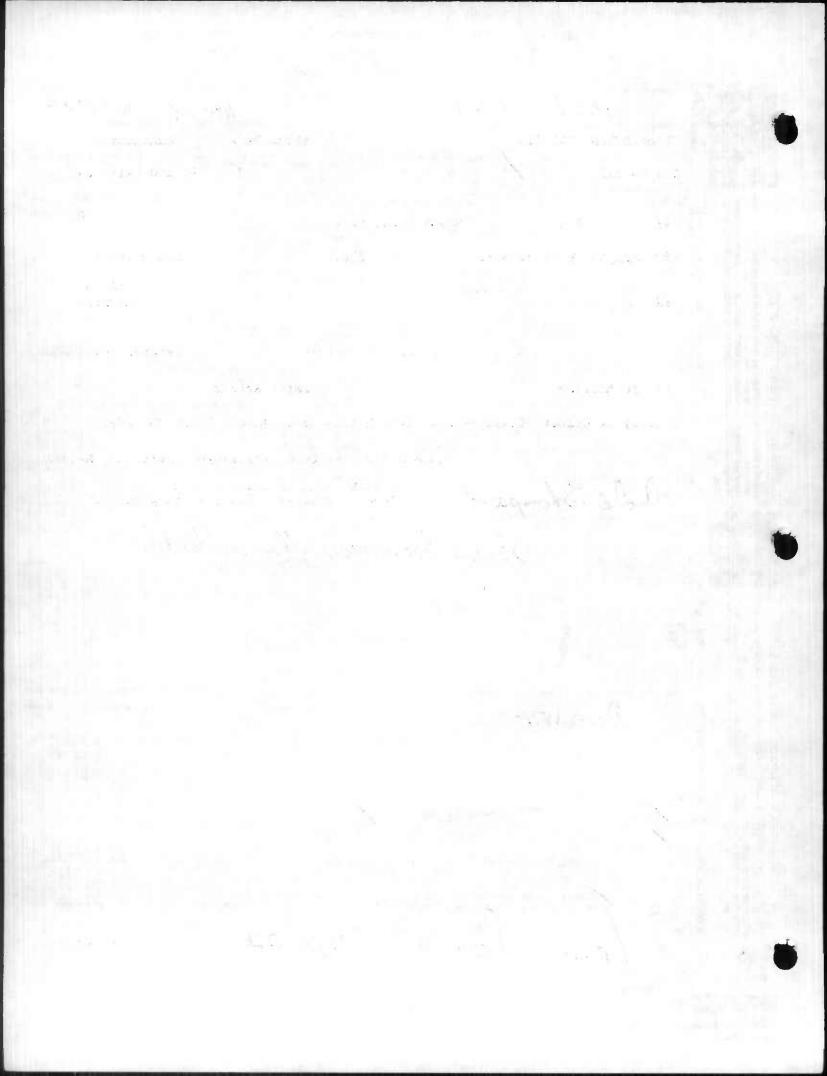
1205 Holton Lane, Takoma Park, MD

22. Name and Address of Facility
McGuire Funeral Service, Inc.

24 hours a

To the within 2

10



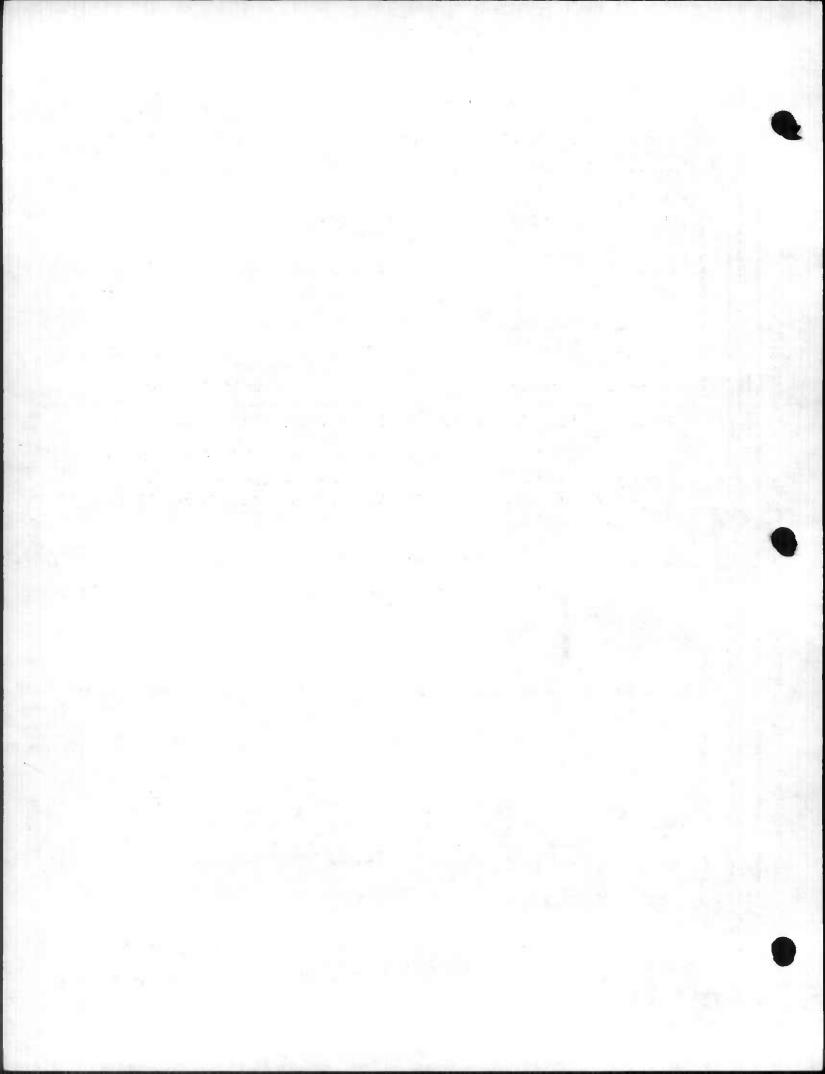
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** WILLIAM DORSEY Nov 5,2000 3:20 Pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Glade Valley Nursing And Rehab Cen, Walkersville Fredrick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 □ F Director 217-12-2849 15,1920 Maryland Usual Residence of Deced the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show to Yes 2 No Director 28e-f MD Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r, or herrs 23s or 2 xaminer must be n 8601 Discovery Blvd. Funeral 21793 U.S.A. 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 ☐Xes 2 ☐ No If Yes, Give 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 42-44 Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 7th State Rd. Comm. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Robert N. Dorsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21793

Walkersville, MD Carrie B. Loud 19a. Informant's Neme/Relationship (Type, Print) nt of Health a if them 27 is or other tra Phyllis Whiten (Daughter) 8601 Discovery Blvd., Walkersville, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any injury or once. Dorsey Chapel Cem. 11/11/00 New London, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service License SNOWDEN FUNERAL HOME, P.A. wale 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respirelory errest, shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finet 1 Dan Stroke disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner per tension Ician and burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): physician the burle Box 68760. Physician/Medical Due to (or as a consequence of): USe signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Noknown þ Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? page 2 s 1 Yes 25 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physicien: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 21 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Matural 5 Pending Ne Hoepital or Attending n 24 hours efter death. Ne Funeral Director: Aft 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 10 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signeture and title of contilled 29c. License number 29d. Date signed (Month, Day, Year) 11-8- CV 043091 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SACEN TAIN! MN 801 TOLL HOUSE MA Ave Frederick Met SAEED 31. Date filed (Month, Day, Year) 32, Registrar's Signature State NOV 6 9 2000 DOLKS

DHMH 16 Rev 6/95

Registrar



State of Manyland / Department of Health and Mental Hydiene

	fle, Lasi)							2. Date of De				3. Time of Death
Evelyn Jane Do	vd							Month Novemb	er 3	, 20	Year 00	10:00 PM
4a Facility Neme (If not institution	on, give street end nur	mber)			4	b. City, Town	, or Lo	cation of Deal	th 4c.	County o	of Death	
Wilson Health	Care Center	r			G	aither	sbu	rg	1	Mont	gome	ry
5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Months	Year Days	If Under 24 Hours	Hrs.	8. Date of Bi (Month, Di January	rth av. Year)		9. Birthp	place (Steta or Foreign http:// York
067-01-5079	1□M 2X F	88	Yrs.					January	30, 19	912	New	York
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(Specify only high	est grade completed)	140-5-1	(Giva	kind of work DO NOT use	done d	uring most o	f workin	9				
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17. Father's Nama (First, Middle	, Last)				T		Name	(First, Middle				
Daniel Joseph I	owd				- 1	Henri	ett	a Kron				
19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street a	and Number	or Rura	Route Numb	per, City or	r Town, S	State, Zip	Code)
Daniel V. Dowd,	Nephew		10812	Larkm	nead	e Lane	, P	otomac	, MD	208	54	
20a. Method ol Disposition		CC	lace of Dispo	sition (Name	of of			Data				own, State
1 ☐ Buriel 2 ☑ Cremetion 4 ☐ Donation 5 ☐ Other (State	tgomery					v. 6,	Reth	esda	. Ma	ryland
21. Signature of Funeral Service	Licenses		22	. Name and	Addres	s of Facility	Rob	ert A.	Pump	phre	y Fu	neral Home
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The second secon		1										
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Immediata Ceuse (Final disease or condition rasulting in death)	a. Con		- hca	ut f.	مال	re					1	weeks
disease or condition resulting in death)	a	Due to (or	- hca	1 1	مان	re. Oct				H		weeks
disease or condition rasulting in death)	b. ante	Due to (or	ras a consequence of the consequ	cdial	مان	Pect	100					weeks
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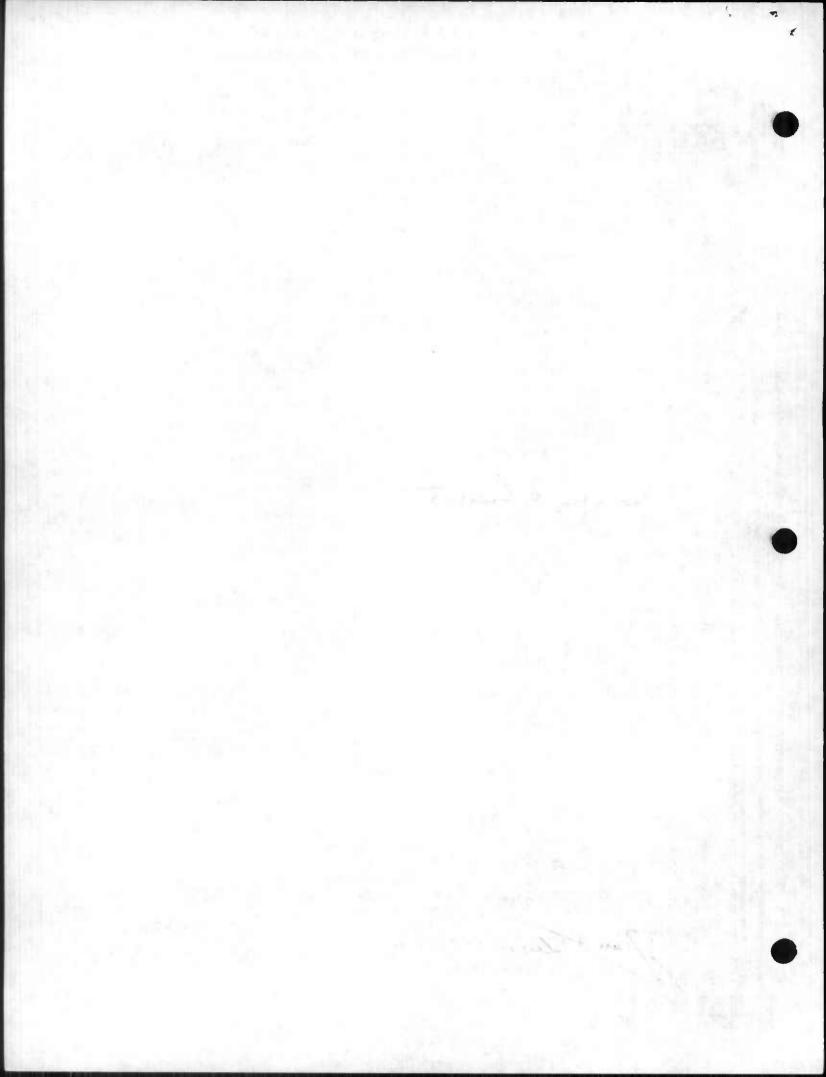
22 Registrar's Signeture

ASPANA .

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 3 7 0 9 3

				Cert	ificate of	Death			Reg. No.		71033
lhuoinian	1. Decedent's Name (First, Midd	e, Last)						2. Dete of De Month	eth Dey	Yeer	3. Time of Death
hysician /Medical	MERRILL	WILLIAM		DRENI	NAN			Nov. 1			11:25 A
Examiner	4e Fecility Name (If not Institutio	n, give street and num	ber)			4b. City, To	own, or Lo	cation of Deeth	4c. County	of Death	
	3208 Pauline Dr	ive				Chev	y Ch	ase	Mont	gome	ry
1	5. Sociel Security Number		7. Age (In yrs. last b		Months Devs		24 Hrs. Min.	8. Date of Birt (Month, Da	th Veec)	9. Birthp	plece (State or Forei
1	579-01-5102	1⊠M 2□F	85	Yrs.	Months Deys	Hours	Mil.	Oct. 1	5. 1915	Wash	ington, I
	Usual Residence of Decedent						-				
	10a. Stete 10b. County		10c. City, Tov	wn or Loca	ation					1	IOd. tnslde City Limi
	MD Mon	gomery	Chevy	Chas	se					40	1 N Yes 2 □ N
l	10e. Street and Number	8			10f. Zip Code				10g. Citizen of V	What Cour	ntry?
I	3208 Pauline	rive			21	0815			U.S.A.		
	11. Meritel Stetus		dent Ever in U,S.	13 W			inin? (Sp	ecify Yes or No		e - Americ	can Indien,
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	3 Widowed 4 Divorced	If Yes, Give	•	10	☐ Yes 2 💢 No	Specify			Specify	Whit	te
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	(Specify only highe	t's Education st grade completed)	168	(Give ki	ent's Usuel Occu	during mos	st of work	ing	16b. Kind of B	USINGSS/ITI	dustry
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1	19e. Informent's Neme/Reletions	hip (Type, Print)	19	b. Mailing	Address (Stree	et and Numb	er or Run	al Route Numb	er, City or Town,	State, Zir.	Code)
1	Kathleen Drenna	ın (Dat	ighter) 4	917 N	N. 17th	Stree	t,	Arlingt	on, VA	2220)7
l	20a. Method of Disposition		20b. Place	of Disposi	ition (Name of atory or other pl			Date	20c. Location -	City or To	own, State
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	4 □ Donetion 5 □ Other (S 21. Signeture of Funeral Service	• • • • • • • • • • • • • • • • • • • •	Natio		Cremato Name end Add			1/2	Falls C	nuren	1, VA
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ı											
l		g Physician: To the I									
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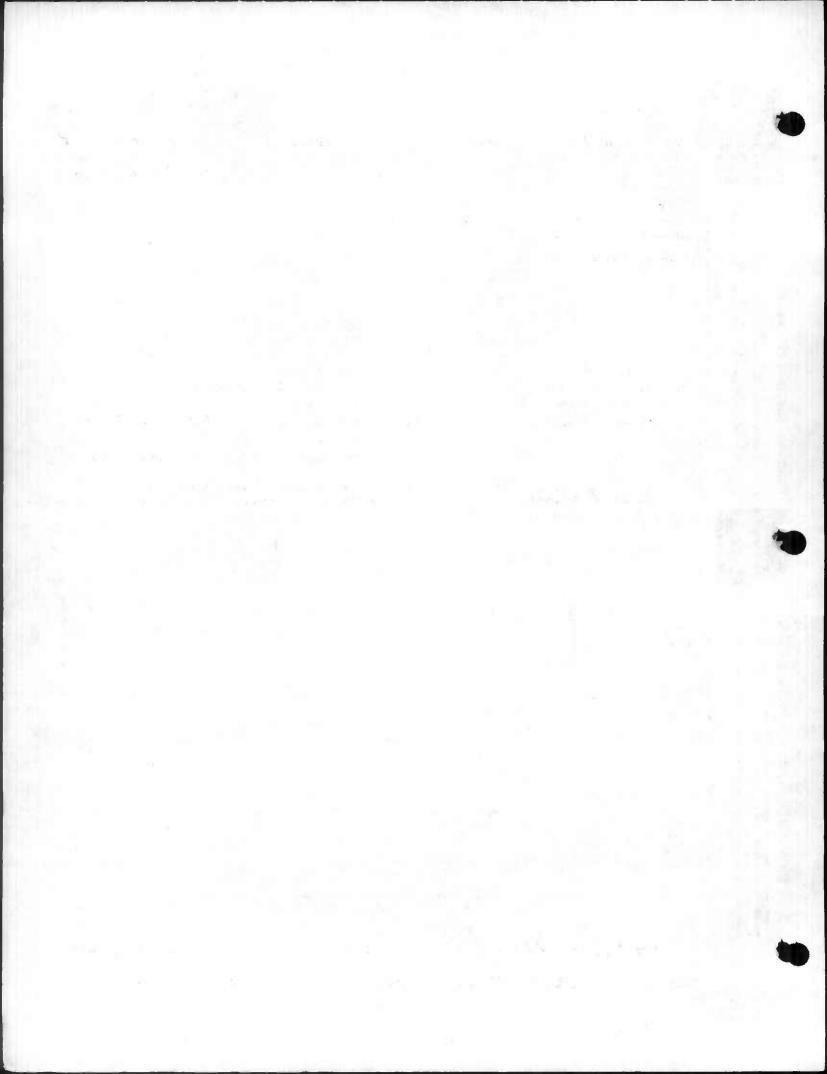


State of Maryland / Department of Health and Mental Hygiene

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1. Decedent's Name (First, Middle, L. Susan C. Durfor 4a. Facility Neme (If not institution, gir Randolph Hills Not institution) 5. Social Security Number 6. 193–26–0994 Usual Residence of Decedent	ve street and number	ber)						Date of De Month	Day	Year		ne of Death
4a. Facility Neme (If not institution, girls Randolph Hills N 5. Social Security Number 6. 193-26-0994	Nursing H	ber)							Day	rear		
Randolph Hills N 5. Social Security Number 6. 193-26-0994	Nursing H	ber)					N	ovemb	er 6, 2	2000	4:	35 am
5. Social Security Number 6. 193-26-0994						4b. City, Tow	m, or Location	on of Deeth	4c. Count	y of Death		_
193-26-0994		lome				Wheato	n		Monte	omery	7	1
Usual Residence of Decedent	Sex 7	. Age (In yrs. I		if Under Months			4 Hrs. 8. I	Date of Bird Month, Da OV 2	6, 1905	9. Birthp Coun Dela	lace (St try) Ware	ete or <i>For</i> e
10a. State 10b. County		10c City	, Town or Lo	cation							Od to de	. 0'- 11-
	****									- '		le City Lim Yes 2011
Maryland Montgome	i y	311	ver Sp	10f. Zlg	- Cada				40. 00			100 42
3508 Farthing Dri	ve				906				10g. Citizen of USA	What Coun	itry?	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	if Yes, Give	es? No	1		V	Hispanic Origi ban, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No n, etc.)		ce - Americ ick, White, by: Whi	etc.	١,
15. Decedent's E	ducation		16a. Deced	dent's Usua	al Occu	pation	of working		16b. Kind of B	lusiness/Ind	dustry	
Elementary/Secondary (0-12)		lor 5+)	life. I	DO NOT u	se retire	ed)	or working		W. 14.	1		
47 5-11 4 11 45 4 444 4			Nurse									
										ne)		
									-			
Sue Dawson / Daug	ghter		3508	Fartl	hing	g Drive	, Sil	ver S	pring,	MD 20	1906	
		ate ca	ametery, cren	netory or o	other ple							9
21. Signature of Funeral Servica Lice	nsee										. MI	200
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last		Due to (or sive D	as a conseq ementi as a conseq	uenca of): .a uence of):								
Part II. Other algnificant conditions of	d	h but not resul	Iting in the ur	iderlying c	ause gi	ven in Part t.		23b. Did t	obacco use co	entributa to	the cau	aa of dea
Chronic Obstructi	ive Lung	Diseas	e					101	Yes 2□ No	3 Prob	ably	l 🔀 Unkn
Hypertension				×						ava	ilable pr npletion	ior to
								1 🗆 Y	es 2X No	1 🗆	Yes	201 No
25. Was case referred to medicat						26. Place o	of Deeth (Ch	eck only o	ne)			
1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	atient 2 E	R/Outpatlen	3 DC	A Ot	her: 🏝 Nurs	ing Home	5 🗆 Resid	lenca 6 □Otr	er (Specity)	
2 1 7 100100111	(Month,	Injury Dey Yeer)	28b. Time of Injury	M 2		ry at rk?	28d.					
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homlcide determined	289. Placa of	Injury - At hon , etc. (Specify)	me, farm, stre	et, factory	, offica					per or Rura	Route f	lumber,
29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	miler: On the basis	s or examination	rledge, death on end/or inv	occurred a estigation,	at the ti	me, date and opinion, deeth	pleca, and d occurred at	lue to the o	cause(s) and madate and place,	anner as sta and due to	ated. the caus	se(s)
29b. Signature and title of certifier	_	~		290	. Licen:	se number		- 2	29d. Date signe	d (Month, L	Day, Yee	r)
Mati c	the.	0/		D	080	2/1/1			Novembe	r 6	200)
30. Name and eddress of person who	completed cause	of death (trom	23e) (Type 1		00:	/++			MOVEMBE	.1 0,	2000	,
					e I	Censino	ton	MD 20	895-211	0		
31. Date filed (Month. Day, Year)	-	istrar's Signatu	-	Los			,cong.				***	
	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Less Charles W. Shear 19a. informant's Name/Relationship Sue Dawson / Daug 20a. Method of Disposition 1 Burial 2 X Cremation 3 I 4 Donation 5 Other (Specification of the Company of the	Never Married 2 Married 1 9 to 9	1 Never Married 2 Married 3 Michowed 1 Divorced 1 Yes 2 No Year or Dates: 15. Decedent's Education 1 Yes 2 No Year or Dates: 15. Decedent's Education 1 Yes 2 No Year or Dates: 17. Father's Name (First, Middle, Lest) College (1-4or 5+) 17. Father's Name (First, Middle, Lest) Charles W. Shearer 19a. Informant's Name/Relationship (Type, Print) Sue Dawson / Daughter 20a. Method of Disposition Burial 2 DCremation 3 Removal from State 4 Donation 5 Other (Specity) 21. Signature of Funeral Servica Licensee	Secondary Seco	Never Married 2 Married 1 Yes 2 Not Yes Give Year or Dates: 1 Yes Yes Give Year or Dates: 1 1 1 1 1 1 1 1 1	1 Never Married 2 Married 1 Yes 2 2 No Year of Dales: 1 Yes 2 2 No Year of Dales: 1 Yes 2 2 No Year of Dales: 1 Yes 2 Yes 2	1 Yess 2 No Nover Married 3 Married 3 Was 2 No Nover Married 3 Was 2 No Nover Married 3 Nover Ma	Sequentially ist conditions Sequ	Types of Name Companies College Colleg	1 Yes 2 No Specify Speci	Specify White Specify	Specify: White Specify: White Specify: Specify: Specify: White Specify: Specify: White Specify: Speci

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Vear **Physician** 10, 2000 4c. County of Death 3:40 AM Evelvn Ellis November /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Havre de Grace Nursina Home Harford Litizens W Under 24 Hrs. 8. Data of Birth (Month Day, Year) 9 Nov. 17, 1929 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2\ F Days 70 169-24-5452 Director Pennsylvania **Usual Residence of Decedent** 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits than "natural", or liams 23s or 28s-f st the Medical Examiner must be notified 1X Yas 2 No Maryland Harford Havre de Grace Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 415 S. Market Street USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black À 3 ☐ Widowed 4 🖾 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Heath and Mental Hygiene. Important: If flem 27 is merised other than "n any injury or other traumatic event, the Med otics. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nurses Aide 8 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dura Baucom unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Wilshire Dr., Aberdeen, MD 21001 Sharon Lee / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Churchville Presbyterian 11/18/00 Churchville, MD 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Lisa Scott Funeral Home Dusa Scott 552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician Immediata Causa (Final disease or condition resulting In death) /Medical Examiner Examiner sician and burlef-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Box 68760. Physician/Medical Due to (or as a consequence of) USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? the Yes 2 No 3 Probably 4 Unknown signed by Ellis, Evelyn P 24b. Wara autopsy findings available prior to complation of cause of death? Was an autopsy performed? Completed To the Hospital or Attending Physicians: sne my within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2. 1 ☐ Yas 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yas 2 Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 1 | Inpetient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (flern 23a) (Type, Print) and 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 13 2000 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Day Month Yaar **Physician** Franklin C. Embon, Sr. November 8, 2000 03:45 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North East Union Hospital of Cecil County Ceci If Under 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Hours Min 1⊠M 2□ F Months Days Director 183-07-4979 86 July 16,1914 Pennsylvania Usual Rasidance of Decedent the Maryland 10a. Stata 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-fah 1 ☐ Yas 2 No Directo Maryland Cecil North East 10e Street and Number 10f Zin Coda 10g. Citizan of What Country? than "natural", or itema 23a or the Medical Examiner must be 21901 Funeral 280 Rolling Avenue death United States 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, etc. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status illed within 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Nevar Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yas 2 🗓 No Specify: Specify: à 3 Nidowed 4 Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Hygiene. 9 Maintenance Mechanic Sun Oil Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If fem 27 is marked othe any injury or other traumado event, page. 17. Fathar's Nama (First, Middla, Last) 18 Mothar's Nama (First Middle Maiden Sumame) Be Daniel Embon Anna Corson 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Code) Daniel C. Embon / Son 500 Georgetown Road, Wallingford, Pennaylvania 19086 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Data 1 X Burial 2 Cramation 3 Ramoval from Stata November 11 4 ☐ Donation 5 ☐ Othar (Specify) St. Mary Anne's Cemetery 2000 North East, Maryland 21 Signature (Funeral Seedle License 22. Nama and Addrass of Facility Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onset and Death Physician Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Examiner tructive Pulmonary Disease Examiner physicien end the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Ceuse (Diseesa or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of) Box 68760, certificate be Physician/Medical Dua to (or as a consequence of): 65 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed page 2 a certificate has 2 No 1 □ Yas 1 ☐ Yas 2 ☐ No Physician: 25. Was cese referred to medical axaminar? funeral director Be 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 2 ER/Outpatient 3 DOA this 28e. Data of Injury (Month, Day Year) 27. Menney of Deeth 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After or Attanding 1 Natural 5 Pending invastigation death. 1 Yas 2 No 2 Accident after death the 3 ☐ Sulcida 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital 24 hours edicai terifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. completely 2 Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 the 29d. Data signad (Month, Day, Year) 29b. Signatura and title of certifiar 29c. Licansa number 11-09-00

DHMH 16 Rev 6/95

State

Registrar

ORIGINAL

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. Cocil ave, North East, MD 21901

30. Name and addrass of person who complated ceusa of daath (Item 23a) (Type, Print)

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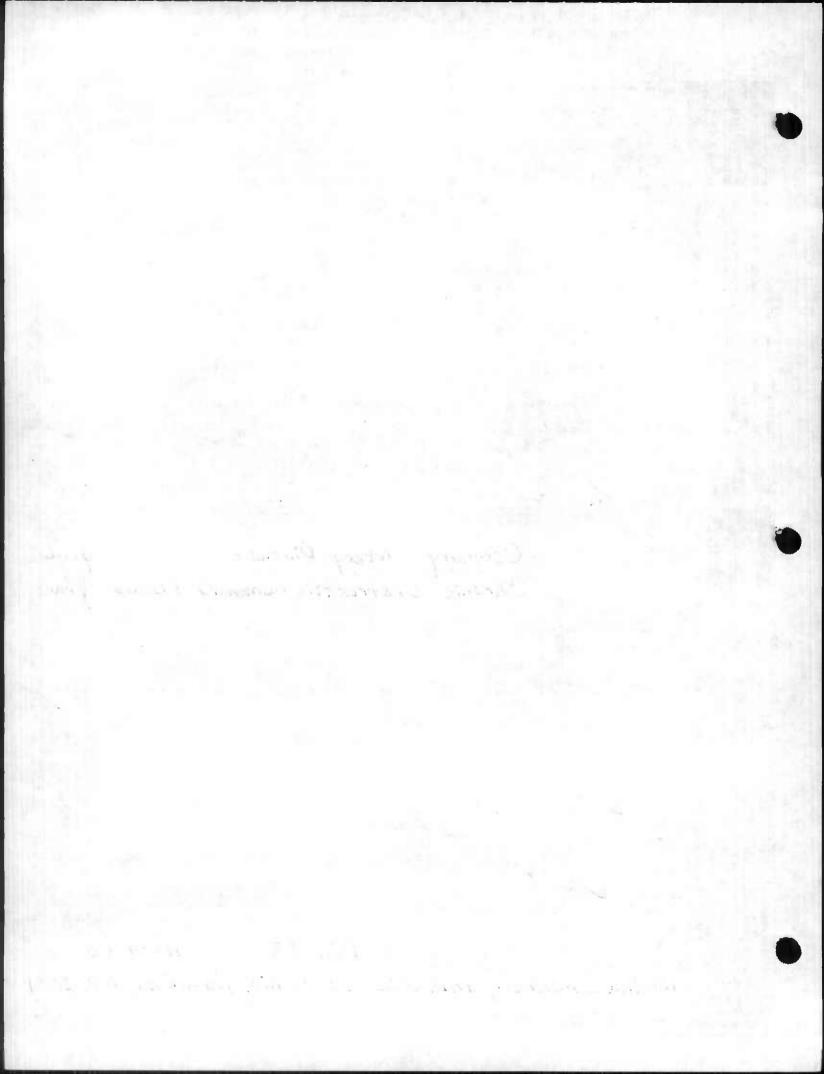
32. Registrar's Signatura

SACHDEV

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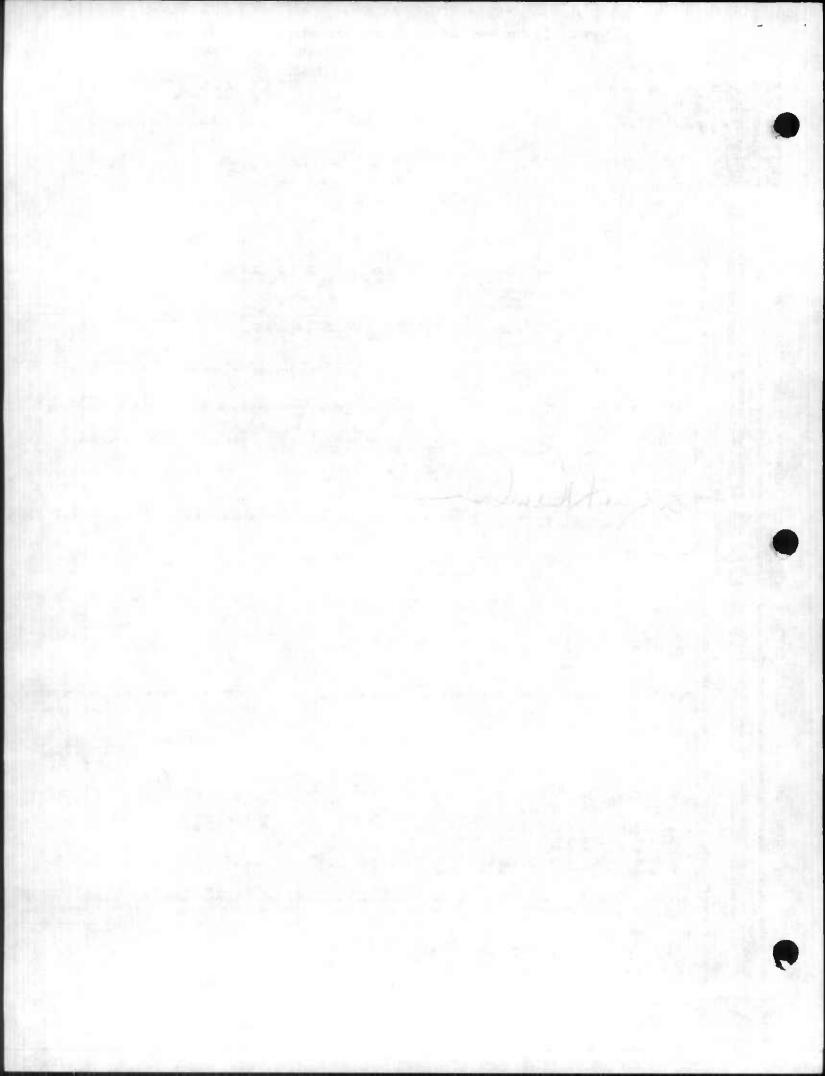
31. Data filed (Month, Day, Year)

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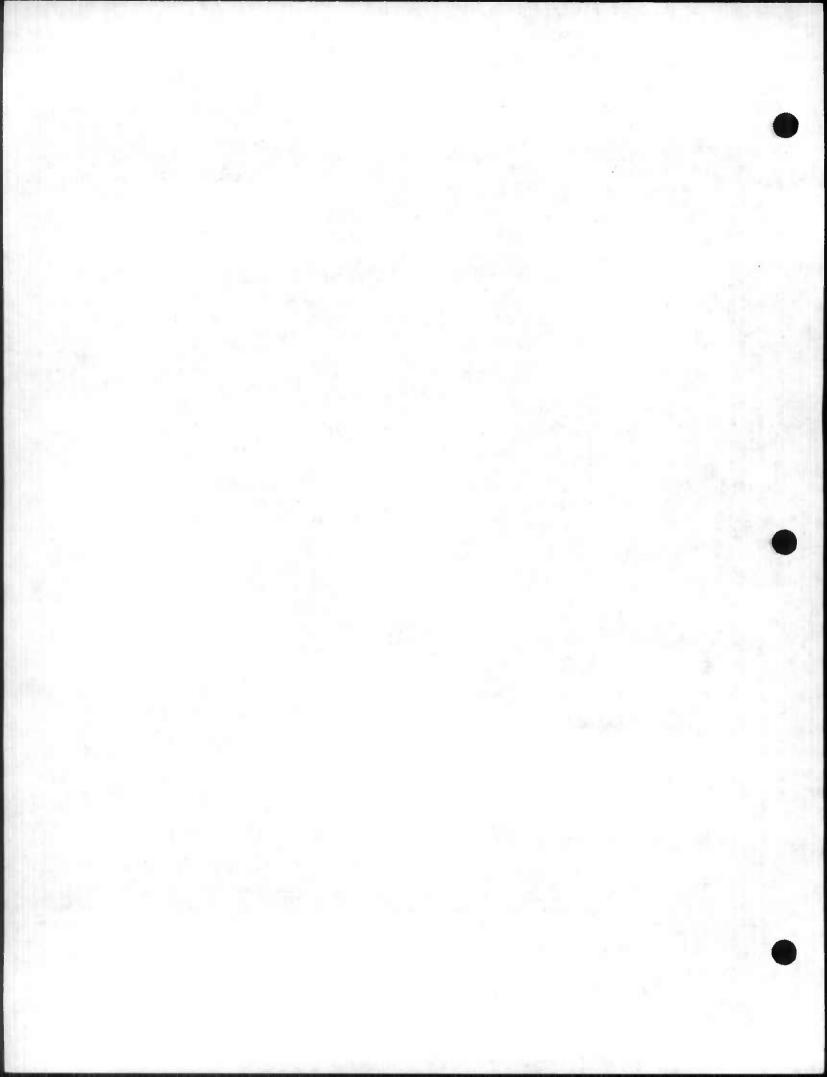
State of Maryland / Department of Health and Mental Hygiene 00 37097

				Certific	cate of	Death		Reg. No.		
	1. Decedent's Neme (First, Middle, L	ast)					2. Dete of D Month	leath Dey	Year	3. Time of Death
Physician /Medical	Bernice	Hershko	owitz	En	ıg			01, 200	0	4:25 a.m
Examiner	An Cantilla Manna Mandalas Institution in	ive street and number	r)			b. City, Town,	or Location of Dee	th 4c. County	of Deeth	
	13713 Ashby Ro	oad			F	Rockvi	lle	Monto	gomer	У
Funeral	Sociel Security Number 6.		ige (In yrs. last l		Inder 1 Year	If Under 24 Hours A	Ain. 8. Date of B	irth (Pay, Year) 1, 1946	9. Birthple	ece (State or Foreign ry) York
Director	095-36-6597	10 M 2/F 5	54	Yrs.	niio Dayo	110010	Oct.3	1, 1946	New	York
	Usuet Residence of Decedent		1 40 O' T						1.0	
or items 23s or 28s-1 show infractions to notified at Finneral Director	10a. Stete 10b. County			wn or Location					10	d. Inside City Limits
1	MD Montgor	mery	ROCK	ville						1 ☐ Yes 2√ No
or 28a-f s be notified	10e. Street and Number			10	f. Zip Code			10g. Citizen of I	What Count	ry?
230		oad		2	20853			U.S.A.		
ofner must	11. Meritel Status	12. Wes Deceden	t Ever in U,S.	13. Wes E	ecedent of H	ispanic Origin	(Specify Yes or Nuerto Rican, etc.)	lo- 14. Rac	ck, White, e	
8 4		1 Tes 2 K			es 28 No	Specify:		Specif	F 73	ite
1	3 ☐ Widowed 4 ☑ Divorced	Year or Detes	i:			оросту.		Specin	, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100
Completed	15. Decedent's (Specify only highest of	Education rade completed)	16	Ba. Decedent's	Usuei Occup	ation during most of	workina	16b. Kind of B	usiness/Indi	ustry
100	Elementary/Secondary (0-12)	College (1-4or	r 5+)	life. DO N	OT use retired	during most of d)				
		3+	Nu	urse				Health		е
B	17. Fether's Neme (First, Middle, Las						Name (First, Middl		пө)	
-		owitz				Evely	n Cohan			
	19e. Informent's Neme/Retetionship	(Type, Print)	15	9b. Mailing Add	dress (Street	and Number o	r Rural Route Num	ber, City or Town,	State, Zip	Code)
E Lagran	Felicia Levy	Daughte	er 3	705 Fe	nton	Dr. A	nnandal	e, VA 2	22003	
5	20e. Method of Disposition	0	20h Piece	of Disposition	(Name of		Dete	20c. Location		
O source	1 Buriel 2 Cremation 3 4 Donetion 5 Other Spe		· King	David	Memo	rial	11/03	Falls	Chur	ch, VA
	21. Signature of Funeral Septice Up	-	Garde		ne end Addre	ss of Fecility	1			
- Suc	- AT	1. 1					al Home	7482 I	Lee H	ighway
	Comment	erme		1			A 22042			
-	23a. Part1. Enterthe disease, or co shock, or head failure. List on	mplicetions that cause y one cause on each	ed the deeth. De line.	o not enter the	mode of dyir	ng, such as car	diec or respiretory	errest,	1	Approximate Intervel Between Onset end Death
ian		/-> A								Onset end Death
ical ner	disease or condition	Chrs	ric lym	pho ant	< ler	kema			O	2 years
	resulting in deeth)		Due to (et es	consequence	e of):			1 1351		1
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Medical	thet initieted events resulting in deeth) Lest	C.	Due to (or es	e consequence	of):					
as the bunal-transit Medical Examir										
		d								
Physician	Pert il. Other significant conditions	contributing to death	but not resulting	in the underly	ring cause giv	ren in Pert I.	23b. DI	d tobacco use co	entribute to	the cause of death?
h							10	Yes 2 No	3 Prob	ably 4 Unknown
d yd E										
2								es en eutopsy tormed?	24b. We	re eutopsy findings eileble prior to
Completed							_ per	rouned t	con	npletion of cause
							10	Yes 2 No		Yes 20 No
Com										165 24160
Be C		Hospitai:			Oth	vor:	Death (Check only			
Plan F		1 Inpa		Outpetient 3[. Time of	J DOA	4 LI Nursir	ng Home 5 Re	sidenca 6 LIOth e how injury occur		')
0	1\□Naturei 5 □ Pending	(Month, D	ay Year)	injury	28c. inju	k? Yes 2∐No	200. 0000.10	o non injery occas		
Certification:	2 Accident investiget	he				165 2 110	294 t costion	(Chant on d No.	has as Owen	I Bouto Number
t	4 Homicide determine	d Zoe. Pieca of I	njury · At home, etc. (Specify)	farm, street, fe	ectory, office			(Street and Num. own, State)	per or mural	Houte Number,
edical	29e. Certifier 1 Certifying F	hysician: To the bes aminer: On the basis	t of my knowled of examination	ge, deeth occu	etion, in my	me, dete and p	lece, end due to the	e cause(s) and m	anner as st	ated. the ceuse(s)
		end manner	steted.							
2	29b. Signetury and Alle of certifler				29c. Licens	e number		29d. Dete signe	Month, L	Day, Year)
	pu	TIM	50		145	0880		11/3/	00	
	30. Name and andress of person wh	completed cause of	deeth (Item 23e	e) (Type, Print)						
						Ave.	Kensing	gton MD	2089	95
State	31. Dete filed (Month, Day, Year)	32. Regis	trer's Signeture			15.1				
State	4011 0 0 2			6 1						



State of Maryland / Department of Health and Mental Hygiene 00 27008

				Certifica	te of	Death		Reg. No.	U	10.	0 0
Dhusisian	1. Decedent's Nama (First, Middle, La	st)					2. Data of Dea	ath Day	Year	3. Time o	f Death
Physician /Medical	Ada	R. Eisel	e				Novembe	r 4, 20		9:50	PM
Examiner	4a Facility Neme (If not Institution, giv	a street end number)				4b. City, Town, or	Location of Death	4c. County	of Death		
	Wilson Health Car			u i i ii ii lind	er 1 Year	Gaithers			gomer		
Funeral Director	777 00 7245	7. Aga (A	n <i>yrs. last bii</i> 1	Yrs. Month				, 1908	9. Birthpli Count I OW		or For
1	Usual Residence of Decedent 10a. Stata 10b. County	10	c. City, Tow	n or Location	-				10	d, Inside C	City Lin
be notified at Director	CA San Mate	o	7	Menlo E						1 🗆 Yes	2 X
ust be n	131 Hedge Road				ip Code 940			United	Stat	es	
Examiner must Examiner must by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Eva Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas:	r in U,S.		edent of ecify Cub 2 No	Hispanic Origin? (5 pan, Mexican, Puar Specify:	Specify Yas or No- rto Rican, etc.)	Specify	ce - America ck, Whita, e		
dical dical	15. Decedent's Education (Specify only highest gra		16a	Decedent's Us	uel Occu	pation during most of we	orkina	16b. Kind of B	usin ess/ Indi	ustry	
ygiene. we then "natur t, the Medical. Completed	Etementery/Secondery (0-12)	College (1-4or 5+)	Но	iiie. DO NOT omemake		during most of wood)		Own Ho	me		
B see	17. Father's Nama (First, Middla, Last, Andrew Rayness						me (First, Middle, e Mason	Maiden Sumer	ne)		
To To	19a. Informent's Neme/Relationship (Type, Print)	198	o. Meiling Addre	ss (Stree	t and Number or Fi	Pural Route Numbe	or, City or Town,	Stete, Zip	Code)	
E 72 E	Susan E. Davis/ D		13	Nedge	Ros	d, Menlo	Park C	Δ 94025			
ant of Has at: If item by or othe	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Ramovel from State	Oh Place o	f Disposition (A ny, crematory of Olitan	eme of	natory	Nov. 6	20c. Location	- City or Tov		
ortan Injur	21. Signature of Funeral Service Licer			22. Nama	end Addr	ess of Facility	DeVol F			***	
8118	1 To 1 C	4				er Park					
ysician Medical aminer	23e. Pert1. Enter the disease, or com shock, or hear relitive. List only Immediata Cause (Final disease or condition resulting in deeth)	. Wrose	psis	consequence o					1	Onset and	da
in and ital-transit	Sequentially list conditions, if any, leading to immediate	b. Du	e to (or es e	consequence o	f):						۳
ng physicia as the bur Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that intileted events resulting in deeth) Last		o to (or as e	consequence o):						
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signed by the ettendid to be detached for use d by Physician/	Vagural bles	eding					10	Y00 2 0 00	3 Prob	ably 4] Unk
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pege Com	Dementia						10	res 2 No	10	Yes 2] No
is certificate director, peg	25. Was case referred to medical examiner?					26. Place of De	eath (Check only o	ne)			
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ath. r: After the funere the funere	27. Menner of Death 1 ⊠Neturel 5 ☐ Pending 2 ☐ Accident investigatio	28a. Dete of Injury (Month, Dey Yo	9ar) 28b.	Time of Injury M		iry at ork?] Yes 2 ☐ No	28d. Describe	now injury occu	rred		
within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	3 Sulcide 8 Could not b 4 Homicide determined	28e. Ptece of Injury building, etc. (1	- At home, fe Specify)	erm, street, fact	ory, office		28f. Location (. City or Tou	Street and Num. vn, Stete)	ber or Rura	Route Nu	m <i>ber</i> ,
M Funera pletely fill edical	29e. Certifier 1 Certifying Pt (Check only one)	niner: On the best of m end manner steted	amination ar	e, deeth occurre nd/or investigation	d et the t	ime, dete and pled opinion, deeth occ	e, end due to the curred at the time,	ceuse(s) and m date end piece,	anner as stand due to	ated. the cause	(s)
To the	29b. Signature and title of certifier			2	9c. Licar	se number		29d. Date signe	ed (Month, L	Day, Year)	
10	J. John	MD			Do	05527	5	Novembe	r 6,	2000	
State	30. Neme and address of person who a ENNY about 31. Date filed (Month; Day, Year)	501N PR	LEDEP	UCK A	VEN	UE, CH	HTHERS	BURG	MC	208	37



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Year **Physician** NOVEMBER 6, 2000 7:15 PM JEANETTE NAOMI FALKSON /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** ROCKVILLE MONTGOMERY HEBREW HOME OF GREATER WASHINGTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Hours 010-09-1148 1 □ M 2 € F 88 MA Director NOV 15, Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itema 23a or 28a-f ahow the Maxical Examiner must be notified at 1 XYes 2 No MONTGOMERY ROCKVILLE Director MD 10e Street end Number 10g. Citizen of Whet Country? 10f. Zip Code USA 20852 6105 MONTROSE ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried WHITE Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P 3 Widowed 4 □ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry PRESCRIPTION DRUGS Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygiens Important: if item 27 ie marked other than eny Injury or other traumatic avent, that page. 4 PHARMACIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ANNE PRICE LOUIS LOUISON 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 907B SENECA ROAD, GREAT FALLS, VIRGINIA 22066 JOSEPH FALKSON/SON 20b. Plece of Disposition (Nama of cemetary, crematory or other plece) 20e. Method of Disposition NOV. 20c. Location - City or Town, State 9 1 ☐ Buriel 2 ☐ Cremetion 3X Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 2000 SHARON, MA SHARON MEMORIAL PARK 22. Name and Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 iter the disease accomplications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory errest, heart failure. List only one cause on each line. Approximate Intarvel Batween Onset and Death **Physician** /Medical Immediate Ceusa (Final diseese or condition resulting in death) Examiner Examiner physician and the bunal-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760 Physician/Medical that initiated events resulting in death) Lest Due to (or as a consequence of): USB Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 1 Yes 2 No 3 Probably 4 Unknown signed t pulmonale by 24b. Wera eutopsy tindings evailable prior to should 24a. Wes an autopsy performed? Completed completion of cause of death? 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifical completaly filled in by the funeral director, Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? edical Certification: 1 Neturel 5 Panding investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signeture end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 55258 November 7, 2000 30. Nama and address of person who completed causa of daeth (Item 23a) (Type, Print) Rockville Maryland 20852 B. Wilks mp 6121 montrose

DHMH 16 Rev 6/95

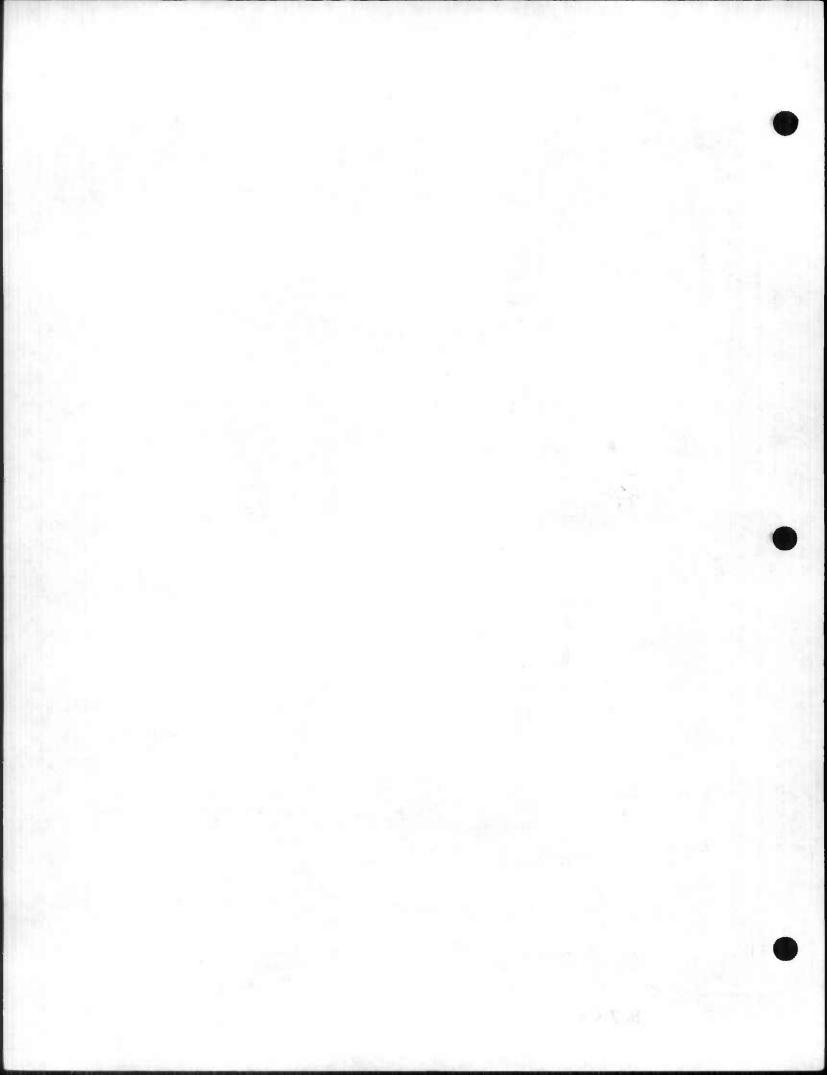
State

Registrar

31. Date filed (Month, Day, Year)

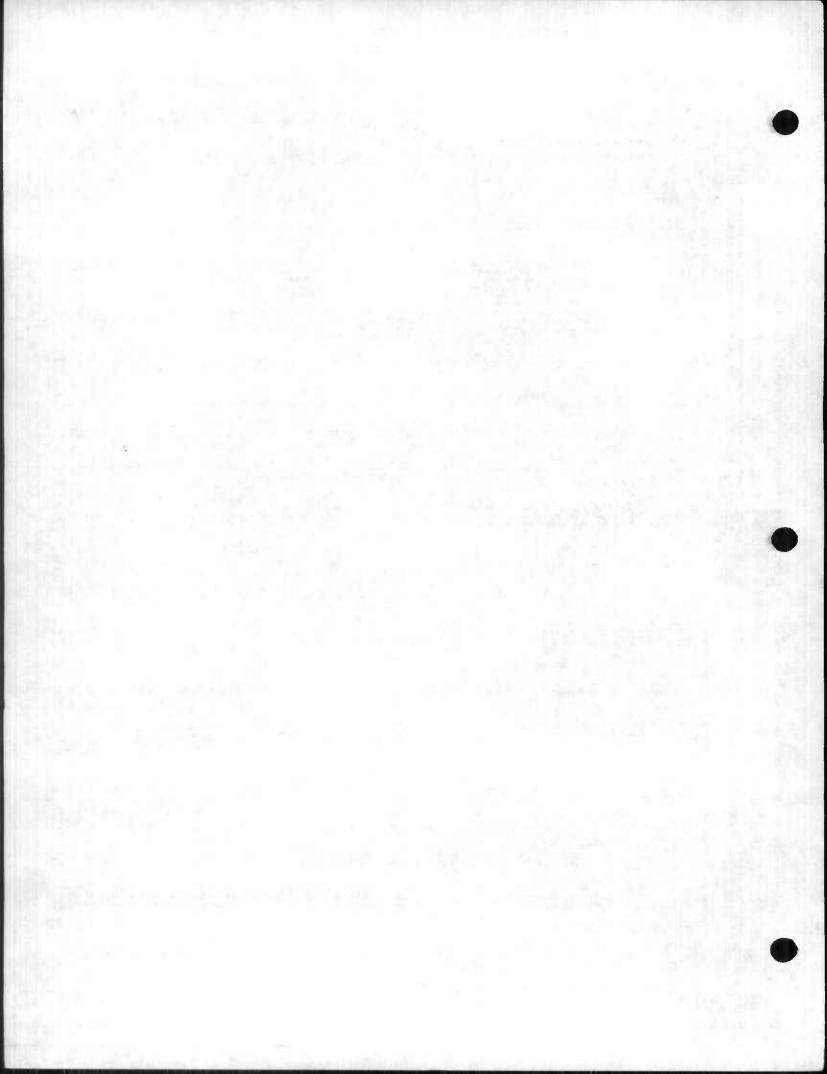
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32 Registrer's Signeture



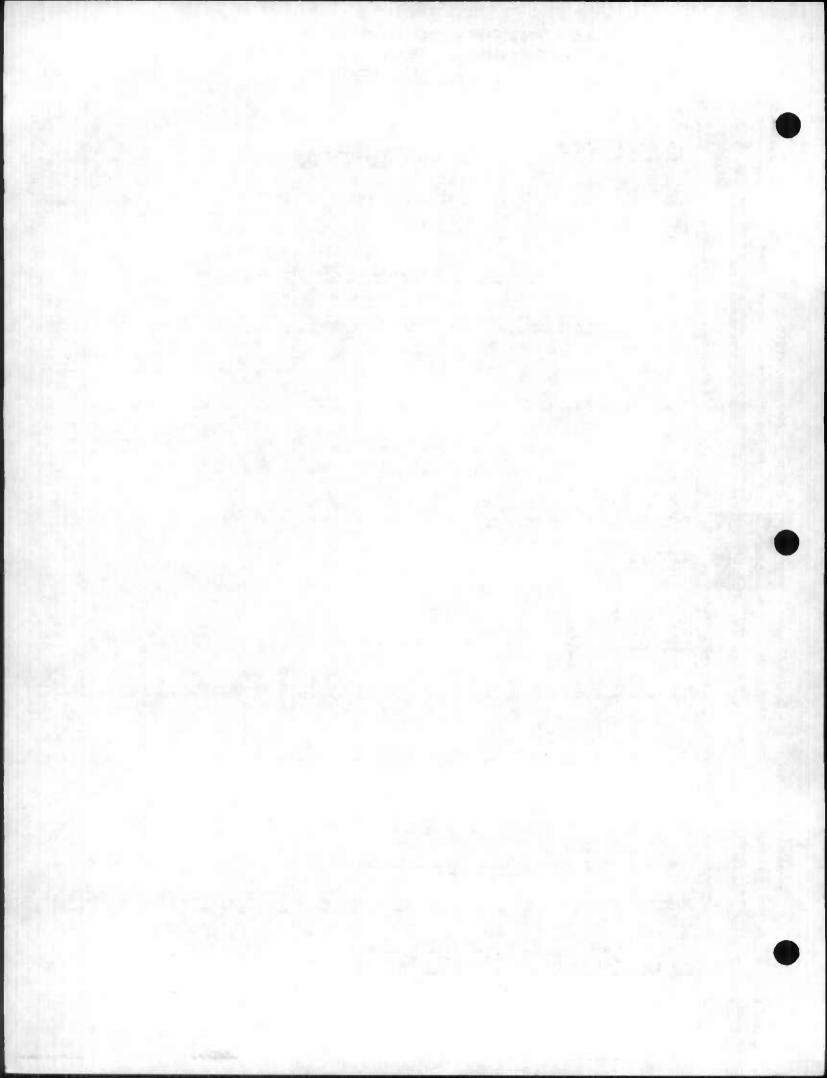
			State of	Marylan		artment o				giene 🕕 1 Reg. No.	0 3	7100)
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	Examiner	4a Facility Neme (If not institution, ga	ve street and numb	er) Case	y Hous	e	4b. City, T	own, or Loca	ation of Death	4c. County	of Death		
		6001 Muncaster Mi	11 Road				Rocky			Montgo			
	Funeral		Sex 7. 1 ☐ M 2 🖾 F	Age (In yrs. I	ast birthdey) Yrs.	Months D	eer If Unde Bys Hours		B. Dete of Bird (Month, De			ace (State or Fo	preign
Ш	Director	Usual Residence of Decedent		70	113.			5	Sept.	16, 1930	Georg	gia	
and a	i i u	10e. State 10b. County		10c. City	, Town or Lo	ocation					10	d. Inside City L	imits
2	28a-f sh notified ector	Maryland Montgome	rv	Pot	omac							1 ☐ Yes 2)	No
6	or 28a-1 show be notified at Director	10e. Street and Number		1200	<u> </u>	10f. Zip Co	de			10g. Citizen of V	What Count	ry?	
3		11914 Goya Drive				2085	54		15.3	United	State	25	
dag	iner iner	11. Merital Status	12. Was Decede Armed Force	ent Ever in U.	S. 13.	Was Decedent It Yes, specify	of Hispenic O Cuban, Mexica	rigin? (Specian, Puerto Ri	ify Yea or No ican, etc.)	- 14. Rac Blac	e - America ck, Whita, a		
0000	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2			1□Yes 2ki					White	e	
8	d b	15. Decedent's 8	Year or Date	95:	16a Dece	dent's Usual O	connetion			16b. Kind of Bu	usiness/Ind	ustry	
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yla	Manth Martin	John	I.	E.	llmann			Mai	cy	Smi	th		
Maryland 21215-0020	p a a	19a. Intermant's Name/Relationship								er, City or Town,		Coda)	
- 5	Health Party	David M. Feinman 20a. Mathod of Disposition	(Husband			4 Goya		Potoma	Date MD	20854 20c. Location -		wn State	-
mor	ant of h	1 Burlet 2 Cremetion 3	Removel from St	ate	emetery, crei	metory or other	pleca)						
a based	E # 2	4 Donation 5 Other (Spec	colorie Tree	Che		ke Crem 2. Name and A	-		-6-2000	Beltsv	ille,	MD	
Balt	Depart of the party of the part	102/XX	7)		Ra	pp Fune	eral &	Cremat		ervices			
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P	hysician	shock, or heart tailure. List onl	y ona cause on eac	ch line.							1	Onset and Dea	an ath
	/Medical	Immediate Cause (Final disease or condition	027	arian (anger							3 years	
E	xaminer	resulting in death)	a		r as a conse							J years	2
2	n and ial-transit Examiner		b										
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760,	a price	Cause (Disease or Injury that initiated evants	G	Due to /or	as a consec	ruance ot):							
89		resulting in death) Last		Due to (or	43 4 0011300	querios ory.							
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O. E	the eth hed fo	Part II. Other significant conditions	contributing to deat	th but not resu	ulting In the u	inderlying caus	e given in Par	t I.	23b. Dfd	tobacco usa co	ntribute to	the cause of d	death?
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Vital Records,	sate has been s page 2 should								10	Yes 2 No		daath?	
		25. Was case reterred to medical	T				26 Pla	on of Doub	(Check only		11	Yes 2 No	
of Vita	Il direct	examiner?	Hospital:	patiant 2 🗆	ER/Outpatie	nt 3 DOA	- United States			dence 6 Oth	ner (Specifi	Hospic	e
of of	£ 70	27. Manner of Death	28a. Date of		28b. Time o		Injury at Work?			how injury occur	-		
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Division	C III	No. 10 Miles											
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Tothe	within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification.	29b. Signature and the of certifier	w.10 111a1110	. Juitod.		29c. Li	cense numbe	r	7 -	29d. Date signe	ed (Month,	Day, Year)	
		1 W)			1	543	75		NOU	420	00	
	20	30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)	373	, ,		7400	120		
		6900 600 510	Cheryl Ay	leswon	th, M	807							
	State	31. Date tiled (Month, Dey, Year)		gistrer's Signa		Sport	1						
	Registrar	NUV U 7 Z	000		10.	popor	- 10						

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State of Maryland / Department of Health and Mental Hygiene

				Cen	tificate of	Death		Reg. No.) ;	3/101
П	E. I.	1. Decedent's Neme (First, Middla, La	st)			G. III.	2. Data of Do Month	eath Day	Year	3. Tima of Death
	Physician/Medical	Jose E. Fernande	s					er 4, 20		5:20 pm
	Examiner	4e Facility Nama (If not institution, given	re street and number)			4b. City, Town	n, or Location of Dee			
4		Holy Cross Hospi	tal			Silver	Spring	Montgo	mery	
	Funeral	5. Social Sacurity Number 6. S	Sax 7. Aga (In yrs.		If Under 1 Year Months Days		Min. (Month, D	rth ay, Year)	9. Birthpl Count	aca (Stata or Foreign
	Director	130-40-0700	66	Yrs.			Feb 4,	1934	Port	
	p	Usual Rasidence of Decedent 10a. Stata 10b. County	10c. Ci	ty. Town or Loc	ation				10	Od. Inside City Limits
	Amyle at all or	Maryland Montgome	100	ver Spi						1 □ Yas 2 No
	or 28s-f	10e. Street and Number	19 311	rver shi	10f. Zip Coda			10g. Citizan of W	hat Count	In?
	The part of		n J		20902				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,
	ther death with the Marylar theres 23a or 28a-f show siner must be notified at Furneral Director	3504 Randolph Ro	12 Was Decedent Ever in I	J.S. 13. W		Hispanic Origin	n? (Specify Yas or N	USA 0- 14. Race	- America	an Indien,
Maryland 21215-0020	72 hours after of natural, or her fical Examiner sted by Fun	1 Nevar Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 24 No If Yas, Giva Yeer or Detes:		Yas, specify Cut		n? (Specify Yas or N Puerto Rican, etc.)	Specify:	whita, a	
0-0	athur ical ted	15. Decedent's E		16a. Decede	ent's Usual Occu	pation	d undine	16b. Kind of Bu	sinass/Ind	lustry
218	ed within 72 ho ygene. er than "naturi it, the Medical. Completed	(Specify only highast gri	College (1-4or 5+)	life. D	and of work dona ONOT use ratire	auring most o	nr working			
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pu	d offin	17. Fether's Name (First, Middle, Last)			18. Mother's	s Nama (First, Middle	a, <i>Maidan Sum</i> ema	1)	
yla	Mend Mend	Silverio Fernand	es			Custo	odia Estev	res		
far	AL SE SE	19e. Interment's Name/Relationship (or Rural Routa Numi			
-	man man	Manuel V. Brito					, Silver S		-	0902
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Balt	Depart Depart Imports any inj ance	21. Signeture of Funeral Service Lice	nsee C.J.				ins Funera Blvd., Wes			ing MD
		23e. Part1. Enter tha disease, or com shock, or haart failura. List only	pligations that caused the dear	th. Do not ente	r the mode of dy	ing, such es ca	ardiac or raspiratory	errast,	Spr.	Approximele Interval Batween
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	death certificate be executed e attending physician and of for use as the burial-transit sician/Medical Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Due to (c	or as e consequ	uence ot):					
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Box 6	ist the death certification of the attending letached for use as Physician/Me		d						1	
	the at the story	Part II. Other significant conditions of	contributing to death but not res	sulting in tha un	darlying causa g	iven in Part I.				the cause of death?
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S,	5 8 5 A								0.45 14/-	All disease
Records,	The law requires are has been sign page 2 should be Completed by	Chronic Renal Fa	ilure					s en autopsy lormed?	ave	ara autopsy findings eileble prior to mpletion of cause
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of Vital	Physician: The this certificate ral director, page TO Be Co	25. Was casa rafarred to medical axaminar?	Manital 37		0		ot Daath (Check only	ona)	-	
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ion	B and C	27. Mannar of Death 1 Danatural 5 Pending 2 Accident invastigation		28b. Tima of Injury	M 1	ork?]Yas 2 □ No	0	how injury occurr		
Division	afor Att	3 Suicida 6 Could not be datarmined		nome, tarm, stre ify)	et, factory, offica		28f. Location City or To	(Street and Number own, Steta)	er or Rura	l Route Number,
	ne Hospi in 24 hou he Funer pletaly fill edical	29a. Cartifier 1 Certifying Ph (Check only one) 1 Medical Example	nysician: To the best of my kno niner: On tha basis of axamina and mannar stated.	owledge, death ation and/or Inv	occurred at the t astigation, in my	ime, date end opinion, deeth	place, end due to the occurred et the time	cause(s) end ma , date and placa, s	nner as st and dua to	ated. the cause(s)
	To the common	29b. Signature and title of certifier	-	_	29c. Lican	se number		29d. Data signed	(Month,	Day, Year)
•	10	- Typha	(0)	123	D	34472		Novembe	r 6,	2000
	,	30. Nama and address of person who	complated causa of daath (Iter	m 23a) (Type), F	Print)					
_		Lynne D. Diggs,	MD 1500 Fores	t Glen	Road, S	ilver S	Spring, MI	20910		
	State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Sign	eture g.	Spork	2				
	1.09.000	10101-				-				

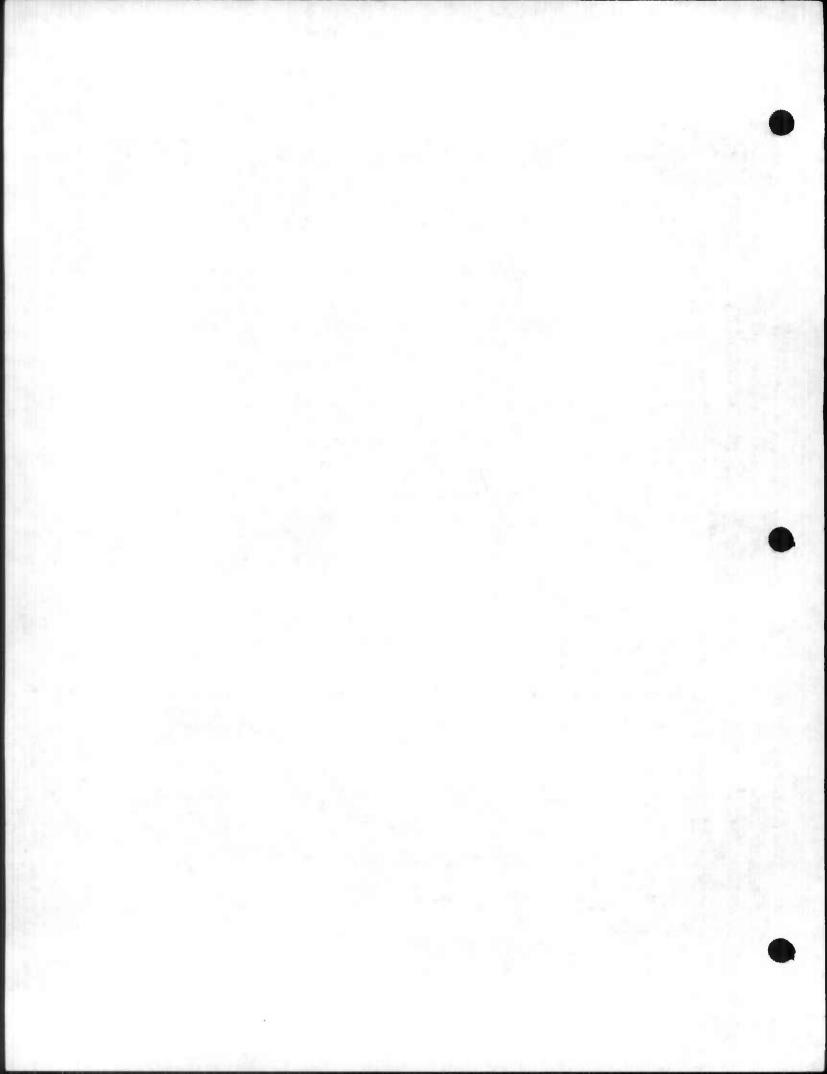


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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				Cer	tificate of	Death		Reg. No.	
Physician /Medical	1. Decedent's Nama (First, Middle Herman Fitz						2. Data of Do Month Nov.	Day 2000	Year 9:45 A
Examiner	4a Facility Nama (If not Institution Annapolis Nursi			on Ce		4b. City, Town, o	or Location of Dea	th 4c. County Anne A	
Funeral Director	5. Social Security Number 578-24-2132		Aga (In yrs. last i		If Under 1 Yaar Months Days	If Under 24 H	rs 9 Date of Bi		9. Birthplace (Stata or Fore Country) Oklahoma
show ed at	Usuat Rasidence of Decedant 10a. Stata 10b. County	mundal	10c. City, To						10d. Inside City Lim 1 ☑ Yas 2 □
death with the Maryland ms 23s or 28s-f show counts on notified at neral Director	Maryland Anne A		Annaı	POILS	10f. Zip Coda 21403			10g. Citizen of V United	Vhat Country?
	1403 Chesapeak 11. Marital Status 1 Never Married 2 Marri	12. Was Deceda Armed Force	int Evar in U.S. IS?		/as Decedent of F Yas, specify Cub		(Specify Yas or N arto Rican, atc.)	o- 14. Race Blace	e - Amarican Indian, ck, Whita, atc.
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L U	(Specify only highas	cottega (1-4)		(Giva I lifa. D	macist	during most of v	working	Pharma	
to the alth and Mental Hygin of other traumatic event, if To Be Co	17. Fathar's Nema (First, Middla, Dock Conrad Fit					18. Mothar's N	lama (First, Middle Payne	a, Maidan Sumam	na)
27 is ma	19a. tnformant's Name/Ratations! Jayne K. Lowe	nip (Type, Print) Niece					Rural Routa Numi		State, Zip Coda)
bemit. Pages 1 and 2 should Department of Health and Men Important: If fem 27 is markes any Injury or other traumatic of DOGS. TO	20a. Mathod of Disposition 1 Burial 2 GCramation 4 Donation 5 Other (Sp		cema	itary, cram	ition (Nama of atory or other pla ke Crema		Data 11/9/00	20c. Location - Beltsvi	City or Town, Stata
permit. Pa Departmen important: any injury any injury	21. Signature of Funarel Sarvice I		min	Me	Name and Addre	ss of Facility S	Service, N.W., W	Inc.	
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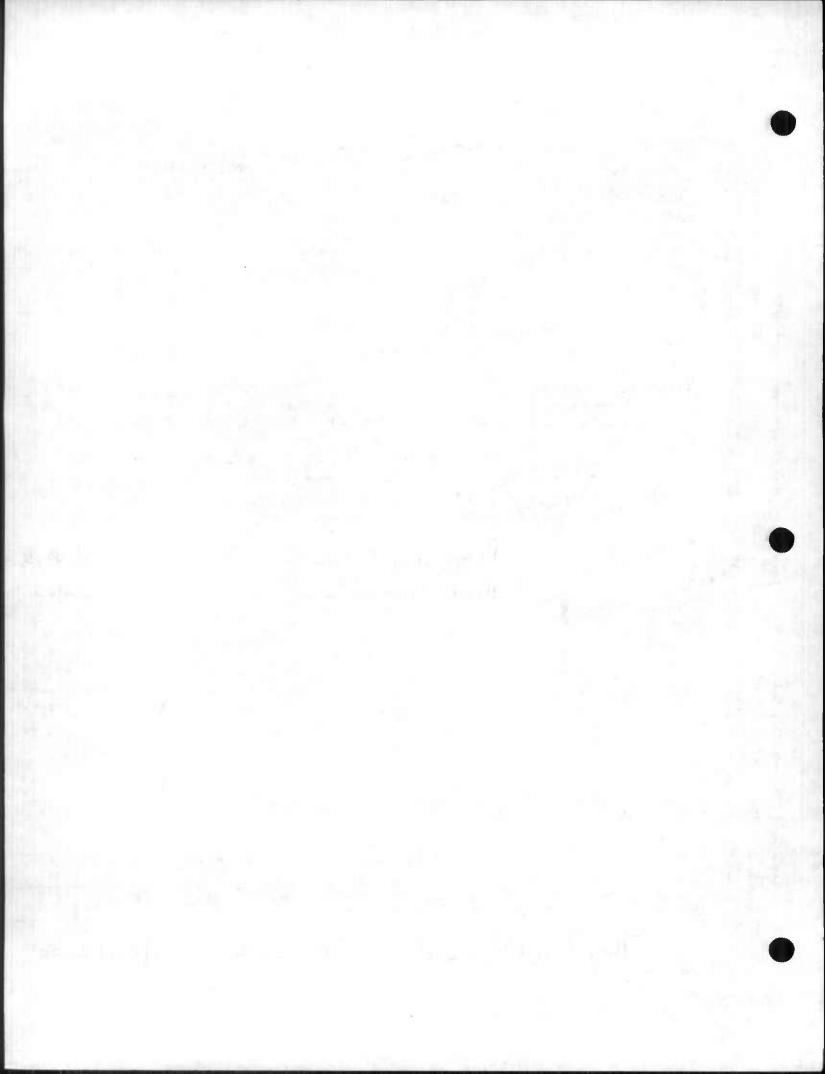
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ral tor	5. Social Security N 399–46–1	975	Sex 1□ M 2M F	7. Age (In yrs. 53	lest birthday, Yrs.	Months 1	Days	If Under a	Min.	8. Data of Bi	, 1947	9. Birthp	placa (Stata or Foraign htry)
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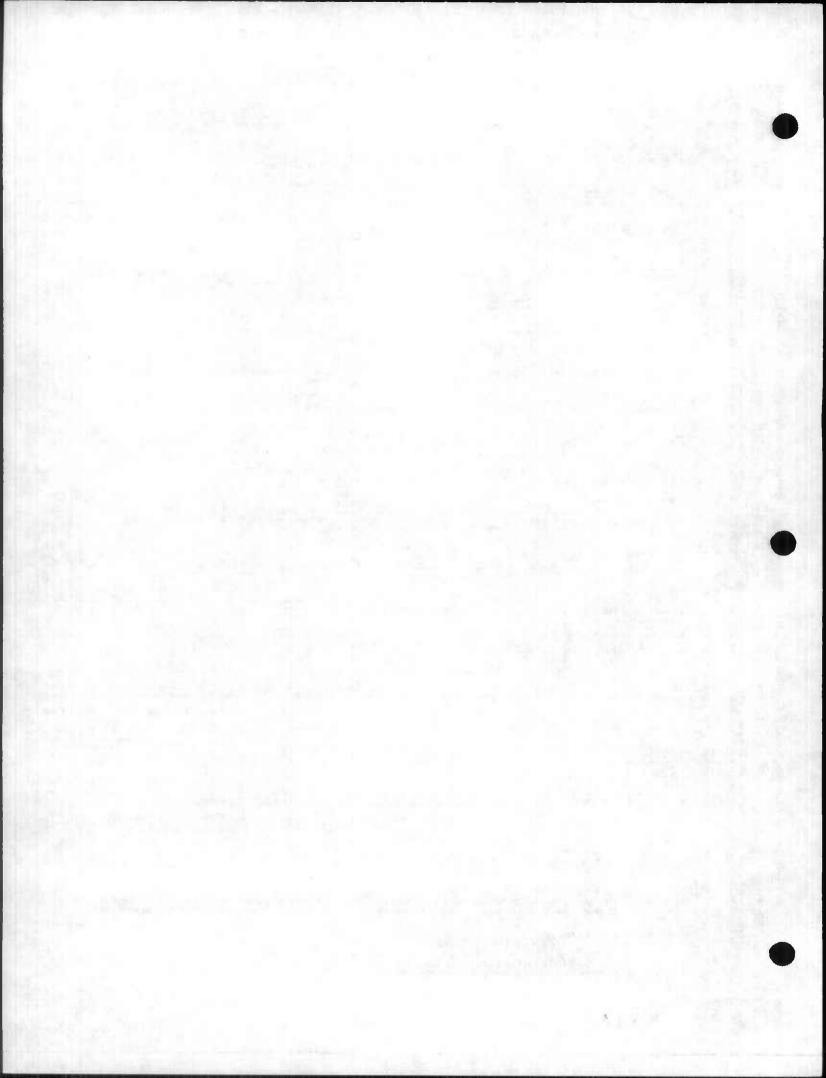
NOV 0 6 2000

Mary Gadow



State of Maryland / Department of Health and Mental Hygiene 00 37104

							Certific	ate of	Death			Reg. No.				
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	/Medica	-	Ab City Name (Mant Institution about and aventual)							Ib. City, Town, or Location of Deeth			4c. County of Death			
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ш	Funeral		5. Social Security Number 6.	Sax 1□M 2⊠F	7. Age (In y		Mont	hs Days	If Under 2 Hours	Min.	8. Deta of Bir (Month, Da	th ly, Year)	9. Birthp	laca (Stata or Foraign		
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	9		Usual Residence of Decedent													
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	D 0 0	- CO	27. Mannar of Death 1 ⊠Natural 5 □ Panding		28a. Dete of Injury 28b. Tima of 28c. Injury at Work?						28d. Describe how injury occurred					
0	Attending or death.	B	2 Accidant invastigation M 1 Yas 2 No													
V.	or de by t		3 Suicide 4 Homicida 6 Could not be determined 28a. Place of Injury - At homa, farm, streat, fectory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Ö	s aft	Certification:														
	hour hour y fills		29e. Certifier 1 Certifying I													
	P. He Fu	edical	(Check only 2 Medicat Examiner: On the besis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and dua to the cause(s) and manner stated.													
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Alt completely filled in by the fur		29b. Signatura and titla of certifiar	Signatura and titla of certifiar / 29c. Licansa number							29d. Data signed (Month, Day			Day, Year)		
	->-0		1 Just 10 015214							4		November 13 200				
	211	-	20 Name and address of names who completed source of death (Name O'2s) (Time Print)										, 2000			
	24		30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print) It Farkas, np VNA North en the sapeake Hospica, Elkton, np													
			17 Far Kas	77			They	2 0	re sup	4	Ke Ho	pick	EIK	lan ho		
	State	9	31. Dete filed (Month, Day, Year)	132.	Registrer's Si	Griedule	10-	11								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle Last) 3. Time of Death **Physician** 1224 GEORGE GLADDEN 2000 November /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY 7. Age (In yrs. lest birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Months | Days | Hours | Min. | 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1∭M 2□F Yrs. 214-12-5555 81 FEB. 11, 1919 MARYLAND Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits N☐ Yes 2☐ No Directo MARYLAND WICOMICO SALISBURY 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 234 Funeral 416 WASHINGTON ST. 21804 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, spacify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Black, White, etc. 1 K Yes 2 No WWII MYes, Give 1 ☐ Never Married 2 ☑ Married ò þ Specify: lf Yes, Give Yeer or Detes: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) BROOKS COURIER SERVICE ARMORED CAR 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) 2 should be fi and Mental F is marked off MARVIN THOMAS GLADDEN PRISCILLA AGNES COX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Department of Heeith MARIE C. GLADDEN - WIFE 416 WASHINGTON ST. SALISBURY, MD 21804 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ODD FELLOWS CEMETERY 11/11/00 LAUREL, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 705 E. MAIN ST. SALISBURY, MD 21804 durth BOUNDS FUNERAL HOME, INC. 23a. Part I Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailura. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Cerebral Bleed /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or as e consequence ot): Box 68760, Due to (or es e consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown DeeTension þ of Vitai Records, 24b. Ware autopsy tindings available prior to completion of ceuse of death? Be Completed 24a. Was an autopsy parformed' 1 Yes 2 No 1 ☐ Yes 2 No or Attanding Physician: 25. Was casa raterred to medicel 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To funerel 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28a. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) filled in by 4 Homicida 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 To the 29d. Date signed (Month, Dey, Year) 29b. Signature and 134768 November 8, 2000 Comp use of death (Item 23a) (Typa, Print) 400 E. Shore Dr. SALISBURY, MD 21104 HICLAND M. J. 32. Registrar's Signature 31. Date filed (Month, Dey, Year)

Registrar **DHMH 16 Rev 6/95**

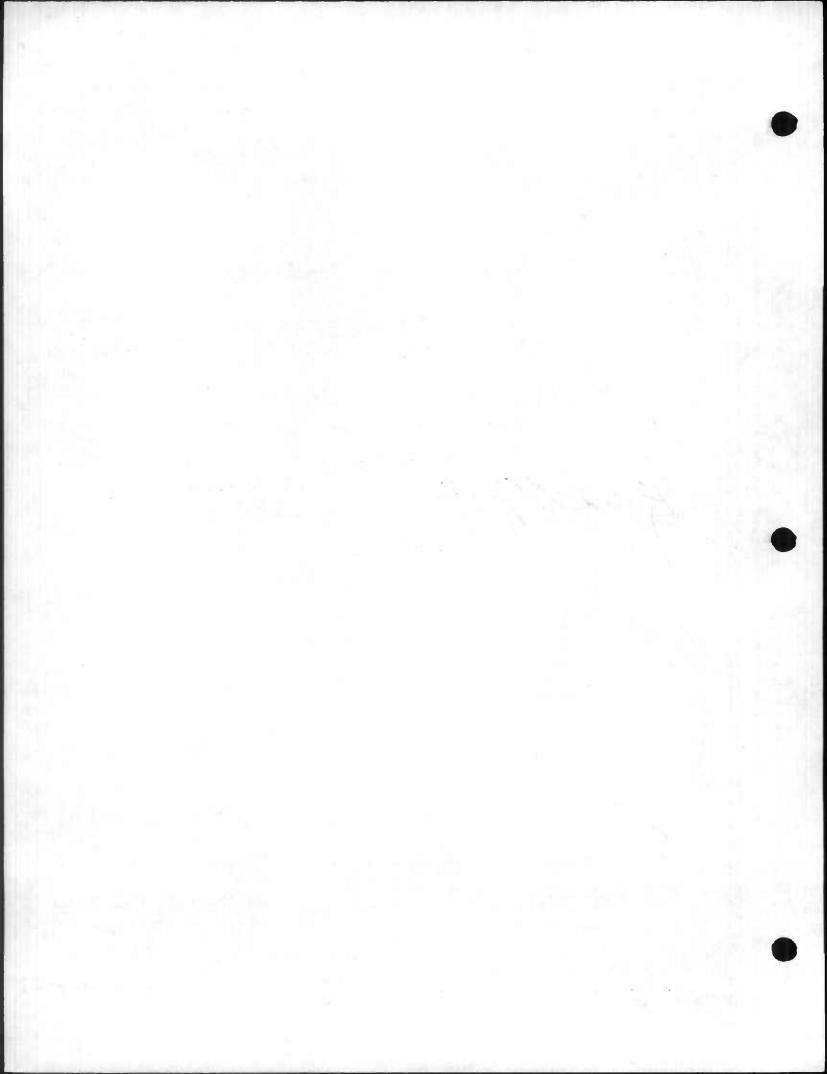
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Dey Month Yaar **Physician** Pauline Ola Gentry November 5, 2000 4:45 am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 96 Wilson Road Rising Sun Cecil Birthplaca (State or Foreign Country) If Under 1 Yee 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Hours 1 □ M 2 X F 246-36-1364 75 Director July 27, 1925 North Carolina Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or items 23s or 28s-f show the Madical Examiner must be notified at 1 Yes 2 No Director Maryland Cecil Risina Sun 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 96 Wilson Road 21911 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Raca - Amarican Indian, Black White etc 1 ☐ Never Merried 2 Married 1 Yes 2 X No If Yes, Give Year or Datas: Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental hygiene. Important: if Item 27 is marked other than "eny Injury or other treumatic event, the second injury or other treumatic event, the second Small Appliance Elementery/Secondery (0-12) College (1-4or 5+) Production Worker Motor Manufacturing 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 0 Andy Gifford Eller Ila Ray Perry 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Tine Hargett Gentry/Husband 96 Wilson Road Rising Sun, MD 21911 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Sleta 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Rosebank Cemetery 4 ☐ Donelion 5 ☐ Other (Specify) 11-8-00 Rising Sun, Maryland 22. Name end Address of Fecility 21. Signature of Funerel Service Licensee R. T. Foard Funeral Home, P. A. 02 111 S. Queen St., Rising Sun, MD 21911 charo 234. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shorts, or heart failure. List only one cause on each line. Approximale Interval Between Onsat and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examiner siclan end burial-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) OPO physician e P.O. Box 68760, Physician/Medical Due to (or as e consequence of): USB BS attending Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Vss 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24e. Was an eutopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific 25. Wes case refarred to medical axaminer?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menger of Death 28b. Time of 28d. Describe how injury occurred edical Certification: 28c. Injury at Work? 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1D/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Within 2.
To the F 29d. Date signed (Month, Dey, Year) 29b. Signatura and title of certifier 29c. License number work 11-06-00 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) AVE North East MD 21901 chdeu M.D. 32. Registrar's Signetura State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** David Joseph Gallagher November 03, 2000 Sr. 1:35PM /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5160 Pooks Hill Road #37 Montgomery Bethesda If Under 24 Hrs. 5. Social Security Number If Under 1 Yaar 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Min Months Days Hours Yrs. Director 66 December 1,1933 Pennsylvania 155-24-9459 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a Steta 10b. County 10d. Inside City Limits x 28a-f show 1 Yas 2 No Director Bethesda Montgomery Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and Pullury or other traumatic avant, tra Medical Franche must be an once. 5160 Pooks Hill Road #37 United States Funeral 20814 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ੴ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Stetus 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Printing 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme, Be Gallagher Theresa Braden 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Margaret Gallagher (Wife) 5160 Pooks Hill Road #37 Bethesda, MD 20814

on of Disposition (Nema of Date 20c. Location - City or Town, Steta 20a. Method of Disposition 20b. Place of Disposition (Nema of cemetery, cremetory or other pleca) 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory T1-4-2000Beltsville, MD 22. Name end Address of Facility Rapp Funeral & Cremation Services 933 Gist Aveune Silver Spring, MD 20910 23a Part 1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiretory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Finel disaese or condition resulting in death) /Medical 7 Weeks Metastatic Non Small Cell Lung Cancer Examiner Due to (or as a consequenca ot): Physician/Medical Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): signed by the aid be detached f Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown Hypertensive and Arteriosclerotic Cardiovascular Disease þ 24b. Were eutopsy tindings available prior to completion of cause of death? been sign Completed 24a. Was an autopsy The law certificate has t 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifical completaly filled in by the funeral director. 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas 2 No 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 1 Natural Certification: 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steled.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the cause(s) end manner stated. Medical 29e. Certifier 296. Signalbus end title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number DOOL 10 D07285 November 4, 2000 30. Name and andress of person who completed cause of deeth (Item 23a) (Type, Print) James Brown, MD 9707 Midical Center Drive Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

DHMH 16 Rev 6/95

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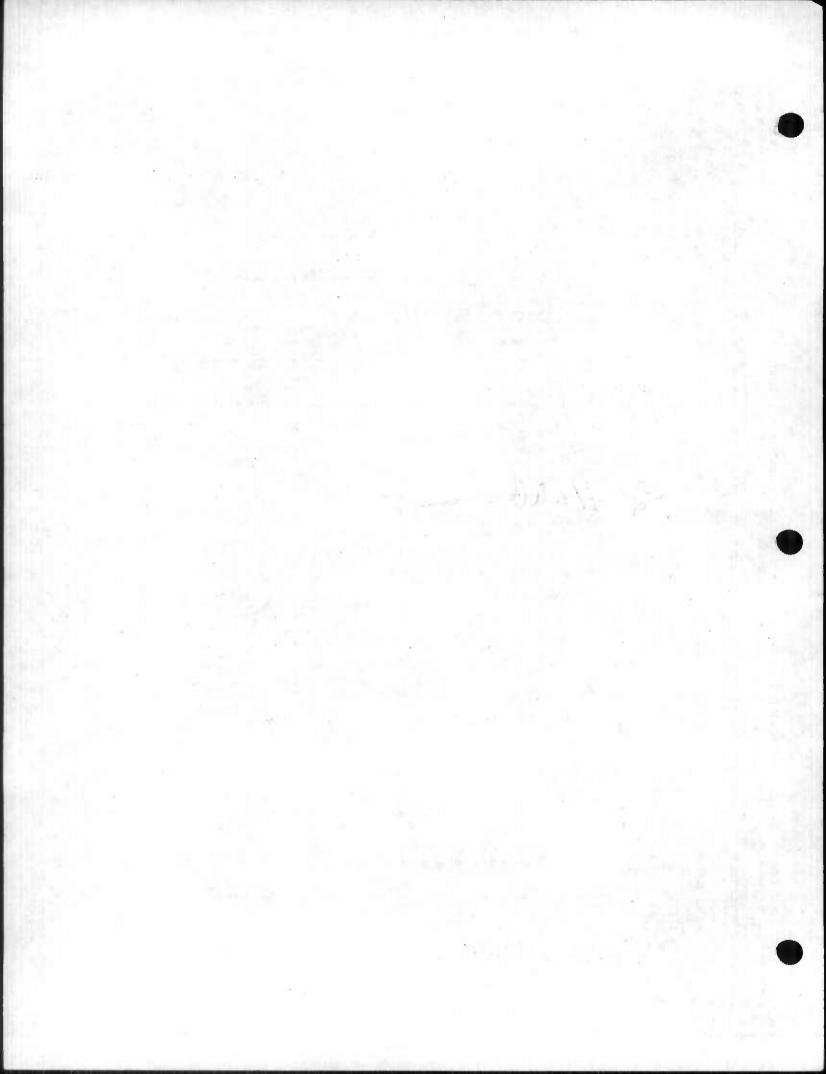
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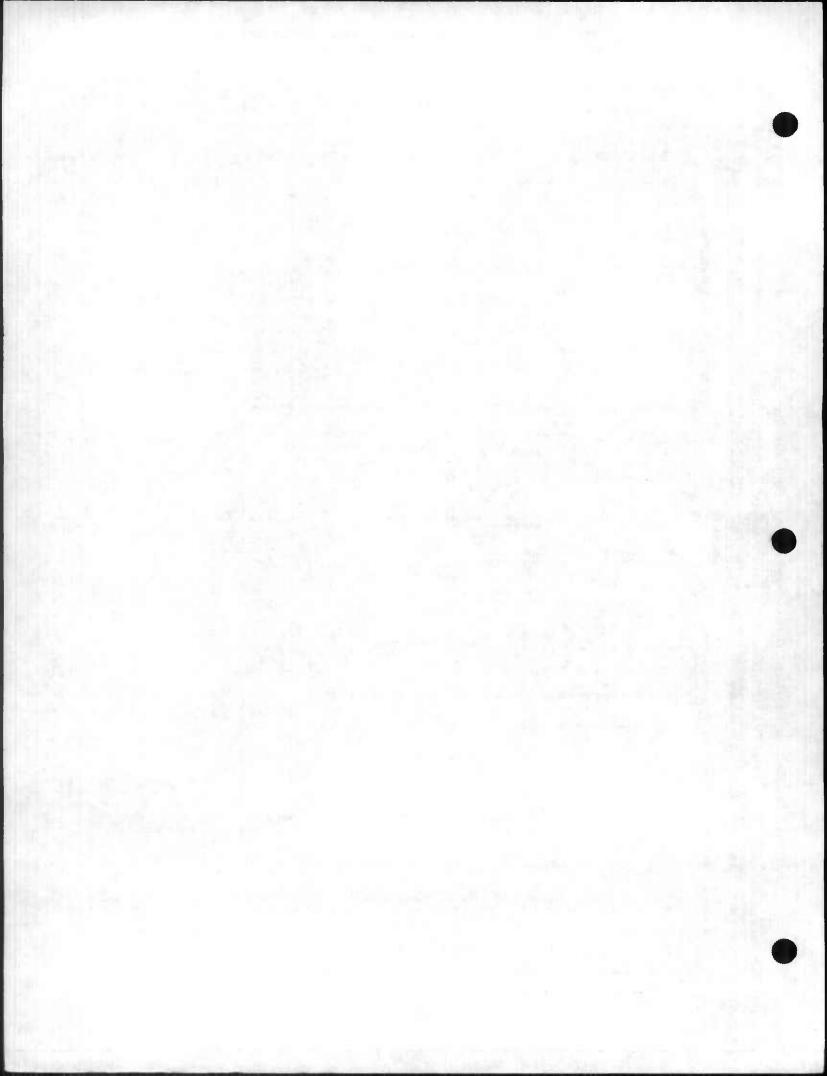
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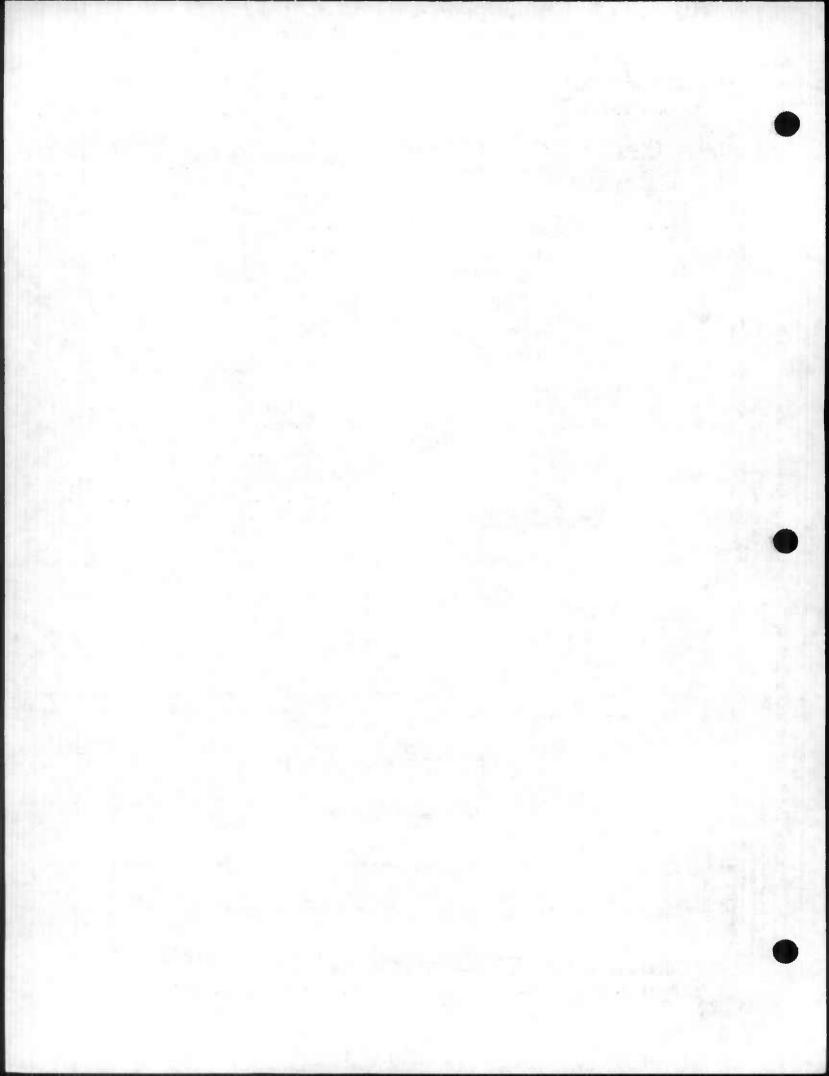
State of Maryland / Department of Health and Mental Hygiene 0 0 37 | 08

	Certificate of Death Reg. No.														
		Decedent's Name (First, Middle, Last)							eth Day	Yeer	3. Tim	e of Deeth			
Physician (Modical	Leonard Joseph Gedrich							Month November		000	1	40 PM			
/Medical Examiner	As Espilita Name (Mast hathatis a		er)	4			4b. City, Town, or Location of De			of Death					
	Holy Cross Hos	pital				Silv	er S	Spring	Mont	Montgomery					
Funeral	5. Social Security Number 6.	Sex 7.	Age (In yrs. last b		der 1 Year	If Under		8. Date of Bir	4h	0 Diebe	Distribute of Fernish				
Director	176-32-0856	1⊠ M 2□ F 79 Yrs. Month			ns Deys	Hours	Min.	Sept. 2	20, 1921	Country) Pennsylvania					
D	Usual Residence of Decedent 10a. Stete 10b. County		10c. City. Toy	vn or Location						Ti	Od. Insid	e City Limits			
or 28s-f show be notified at		tsville								/es 2☑No					
5 40 B	10a, Street and Number		10f.	10f. Zip Code					10g. Citizen of Whet Country?						
h with the state of the state o		2			USA										
flor douth v flore must flore must	11. Merital Status	12. Wes Decede	12. Wes Decedent Ever in U,S. 13. Was Decedent If Yes, specify			of Hispanic Origin? (Specify Yes or N Cuben, Mexican, Puerto Rican, etc.)				e - Americ		٦,			
72 hours after death with the Marylar natural; or items 23e or 28e-f show dical Exemples must be notified at shed his Eumanal Director	3 Widowed 4 Divorced	1 X Yes 2	1 Tx Yes 2 □ No			Specify:	i, ruenc	rican, etc.,	Specify: White						
TZ he	15. Decedent's ((Specify only highest g	Education rade completed)	166	Decedent's U (Give kind of	work done	during most	f of work	ing	16b. Kind of B						
within ene. then the Med	Elementary/Secondary (0-12)	College (1-4c	or 5+)		DO NOT use retired)										
Hygie Hygie Bhar Bhar Bhar Bhar Bhar Bhar Bhar Bhar		2	2 Purch				4- 11	- (1000)		ectronics					
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should be not marked marked marked To F								Cybuls!							
2 25	19a. Informent's Name/Reletionship									City or Town, State, Zip Code)					
	Gloria A. Gedric	h / Wife				., Hy	atts		Marylan		0782				
or of the	20e. Method of Disposition 1 Burial 2 Cremation 3 Removel from Stete 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Fort Lincoln Cemetery 11/4/00 Brentwood								od, N	Mary]	Land				
permit. Pa Departmen important: any injury asse.	21. Signature of Femeral Service Lice	ensasy	11	22. Name	end Addre	ss of Facilit	y Hir	nes-Rina	aldi Fun	eral	Home	2			
Dep Man	X/S/	11800 New Hampshire Avenue Silver Spring, Maryland 20904													
	23a. Part1. Enter the disease, or co	mplications that caus	sed the death. Do	1						1	Approxi				
Physician	shock, or heart failure. List only	y one cause on each	n line.									Between and Death			
/Medical	Immediete Cause (Finel	Immediate Cause (Finel										3			
Examiner	disease or condition resulting in death)	a. Asp	iration							1 1	rour	days			
	5	Cha		consequence	or):					1					
betr Insit		b. Stroke													
executed in and ial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	Due to (or as e consequenca of):													
flicata be expression as the buria	Ceuse (Disease or injury that initiated events	C	Our to force o		Α.										
e death certificate be executed the attending physician and hed for use as the burial-transit vs.c.lan/Medical Examir	resulting in death) Last		Due to (or es a	consequence	or):										
certification of the same of t	d														
death o															
at the death of by the attendetached for up	Part II. Other significant conditions	n the underlying cause given in Pert I.			23b. Did	3b. Did tobacco use contribute to the cause of do 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unit									
that the death certed by the attending detached for use	1 □ Yee 2 □ No								3 Pro	bably	4 Unknow				
8 65 A		Ode Was as suitant.									fore outco	osy findings			
The law requires are has been sign page 2 should be Completed by								24e. Wes en eutopsy performed?			vailable pr	rior to			
has b										ot	completion of cause of death?				
F # 8 0								10	Yes 2 No	1 [□Yes	2⊠ No			
ysician: Thy secontificate director, pag						26. Plece	of Dee	th (Check only	one)						
	1 Yes 25 No	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other							ner (Speci	fy)					
aling Phys. h. After this funeral d		28a. Date of In	28a. Date of Injury (Month, Dey Year) 28b. Time of Injury					28d. Describe how injury occurred							
Attending in death. Ctor: After by the fune	1 ☑Neturat 5 ☐ Pending 2 ☐ Accident investigeti		20) 1047	М		Yes 2□	No								
	3 Suicide 6 Could not determine	20e. Place of injury - At nome, ferm, street, rectory, onice						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
al or A		building, etc. (Specify)													
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert		thysician: To the beaminer: On the basis end menner	of examinetion a									ise(s)			
ithin outh	29b. Signeture and title of certifier 29d. Dete signed (Mon											ar)			
	D 37975								November 1, 2000						
10	(//////	110/11	10.0		р 3	/9/5			Novembe	r I,	2000	J			
	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) J. Indrisano, M.D. 10801 Lockwood Drive, #280, Silver Spring, Maryland 20901														
	J. Indrisano, M.		THE SECOND SECON	d Drive	, #28	O, Si	lve	Sprin	g, Maryl	and	2090	01			
State	31. Dete filed (Month, Day, Year)		strer's Signeture	4 1	a Va	,									



State of Maryland / Department of Health and Mental Hygiene 00 37 109

			Cei	rtificate of	Death		Reg. No.		
, ,	1. Decedent's Neme (First, Middle, La.	st)				2. Date of Month	Death Dey	Year	3. Time of Death
sician edical	John T. Gibson						5, 2000	1,001	9:33 AM.
er	4a Facility Name (If not institution, give	e street and number)			4b. City, Town	n, or Location of De		y of Death	
	Carriage Hill Nur	sing Home - B	ethesda	a	Beth	nesda	Mon	tgome	rv
Ì	5. Sociel Security Number 6. S	ex 7. Age (In yrs.	lest birthdey)	If Under 1 Yea Months Days	r If Under 24 s Hours	Hrs. 8. Dete of	Birth Day, Year)	9. Birth	plece (State or Foreig
l	058-07-3637	MM 2□ F 88	Yrs.	World Day	110010	Oct.	7, 1912	Ohi	
	Usuet Residence of Decedent 10a. Stete 10b. County	100 6	hi Taum ar La	antina					40d Incide City Limits
	10a. Stete 10b. County	10c. G	ly, Town or Lo	calion					10d. Inside City Limits 1 Yes 2 No
	D.C.		Washi	ngton, D	.C.				
	10e. Street and Number			10f. Zip Code	0011		10g. Citizen of		intry?
	4830 Glenbrook F				0016			S.A.	
	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	,S. 13. \	Was Decedent of If Yes, specify Cu	Hispanic Origin Iban, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No- 14. Ra	ce - Ameri ck, White,	can Indien, , etc.
	1 Never Married 2 Married	1 X Yes 2 ☐ No If Yes, Give		1□ Yes 2⊠ No	Specify:		Specia	y: W	hite
ŀ	3 Widowed 4 Divorced	Year or Detes:							
l	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usuel Occi kind of work don	e durina most o	of working	16b. Kind of E	usiness/in	ndustry
	Elementery/Secondery (0-12)	College (1-4or 5+)	inte. L	DO NOT use retir Write			Journ	nalis	m
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	John Gibson, Jr					ha Polla		110)	
			1.						
	19e. Informent'a Neme/Retationship (or Rurel Route Nu			
	Mary Gibson - Wi		1	Glenbroo	ok ka. N	W., Wash			
	20a. Method of Disposition 1 D Buriel 2 Cremetion 3 D	Removal from State	cemetery, crem	netory or other pi		Dete	20c. Location		
	4 Donetion 5 Other (Specific			Cremato		1	Falls C		
	21. Signeture of Funeral Service Licer	1500	22	2. Name end Add	ress of Fecility	Joseph G	awler's	Sons, Inc.	
	1 11 11 LL x	Villace.	5	130 Wisc	. Ave.	NW., Was	hington,	D.C.	20016
	23a. Part1. Enter the disease or com shock, or heart failure, list only	plicetions that consed the dee	h. Do not ent	er the mode of dy	ying, such as ca	ardiac or respirator	y arrest,	1	Approximate Intervet Between
	and the state of t	One decise on partition.						1	Onset end Deeth
	Immediate Ceuse (Finet disease or condition	0	77					1	0.4
	resulting In deeth)	a. Congestiv	e Hear		'e		7	1	24 Hours
		Atheroscl			14 00000				37
	Sequentially list conditions	U	or es e conseq		Isease_			-	Years
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	that withered events	C. Due to (c	or es a conseq	uence of):					
	resulting In death) Last			,				i	
		d							
	Part It. Other significant conditions o	ontributing to death but not re-	ulting in the u	nderlying cause (niven in Pert I	23h [ld tobacco use c	ontribute	to the cause of death
					givon in r oiti.				obably 4 Unknow
	Alzheimers Disea	ise, Urinary R	etenti	on				•	
						24a. W	es an autopsy	24b. V	Vere eutopsy findings vaileble prior to
						P	erformed?	C	ompletion of cause f deeth?
							- T		
	Of Manager of and Assessment and			~			☐ Yes 2X No	1	☐ Yes 2☐ No
	25. Was case referred to medical exeminer?	Hospitel:		_ [0	Nation .	of Deeth (Check or			
ı	1 ☐ Yes 2 🛣 No 27. Menner of Death	1 ☐ Inpatient 2 ☐	ER/Outpetier 28b. Time of	IL SLI DOA	400 INUIS	sing Home 5 R	esidence 6 Ot be how injury occu		ify)
	1 Neturel 5 Pending	28a. Date of Injury (Month, Day Year)	tnjury	W		and the same	be now injury occu	neu	
ı	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 No		- (Canadand Alu-	hara Du	and Dougla Aliambay
	4 Homicide determined	28e. Ptece of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factory, offic	0	City or	n (Street and Nurr Town, State)	ber of Hui	rai Houte Number,
	(Check only 2 Medical Exan	ysician: To the best of my kno niner: On the besis of examine	wiedge, deeth	n occurred et the vestigetion, in my	time, date and opinion, death	plece, end due to i	he cause(s) end me, date end plece	enner es	stated. to the ceuse(s)
	one)	end menner steted.							
	29b. Signature and little of certified			29c. Lice	nse number		29d. Date sign	ad (Month	, Dey, Year)
	> sauce	S		2 3 10	D35579		Novemb	per 6	, 2000
1	30. Neme and eddress of person who	completed cause of deeth (tte	m 23a) (Type,						
	Susan J. Miller,	MD. 6844 Tu1	ip Hil	1 Terr	Bethe	sda. MD.	20816		
	31. Dete filed (Month, Dey, Year)	32. Registrer's Sign							
ı	NOV 68 2	non serve	19.	Annak	2				



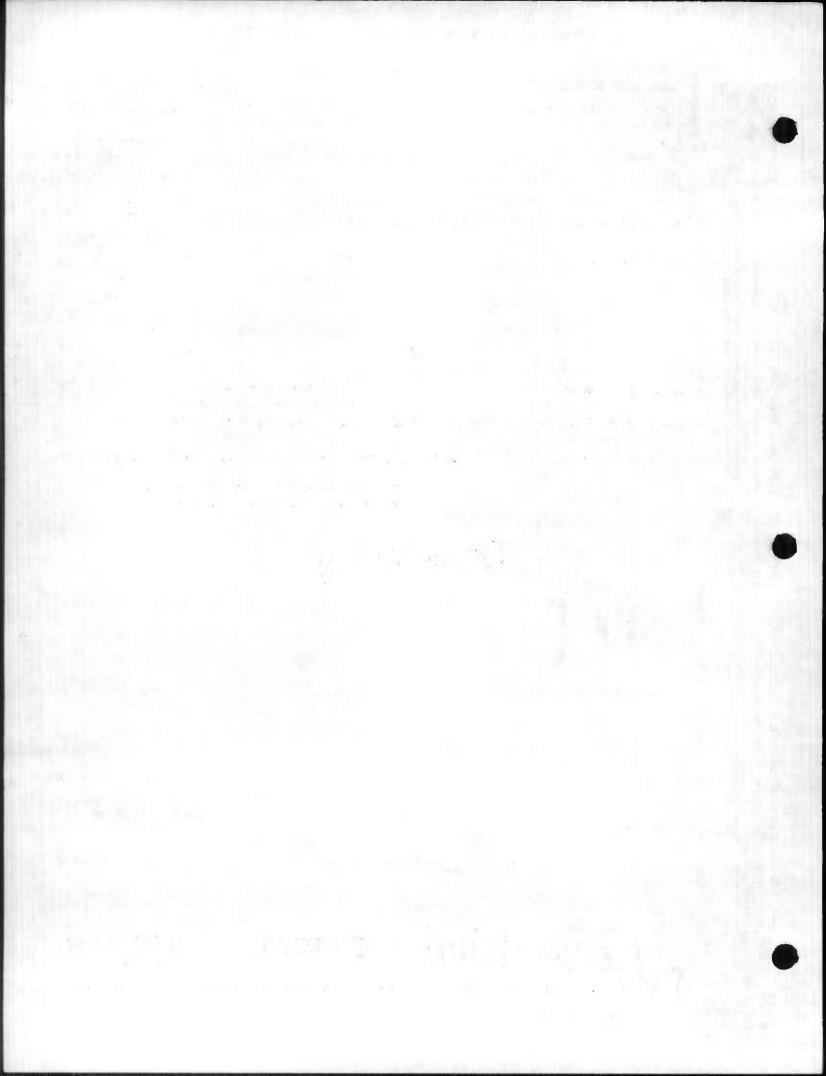
State of Maryland / Department of Health and Mental Hygiene 0 0 37 1 1 0

		Certificat	e of Death	Reg. No.	37110
Physician	1. Decedent's Neme (First, Middle, Last) Arnold	Gimpe	F1	2. Dete of Death Month Dey	Yeer 3. Time of Death
/Medical Examiner	4a Facility Neme (If not institution, give street and		4b. City, Town, or Loc Silver Sp	ation of Death 4c. County	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthdey) If Under		8. Dete of Birth (Month, Dey, Year) 6/28/1926	9. Birthplace (State or Foreign Country)
Director	Usuel Residence of Decedent	74 Yrs.		6/28/1926	New York
tanyian rahow sd.at	10a. Stete 10b. County Illinois (ack	10c. City, Town or Location Northbrook	k		10d. Inside City Limits 1 ★ Yes 2 □ No
with the Maryla a or 28a-f shor be notified at Director	10e. Street and Number	10f. Zip	Code	10g. Citizan of V	
her death with the result to single the result to s	1250 Rudolph 11. Meritei Status 12. Wes D		ent of Hispanic Origin? (Spec	tify Yes or No-	e - American Indien,
Dy by	1 Never Merried 2 Merried 1 1 Yes, 3 Widowed 4 Divorced Year o	s 2 No	dent of Hispenic Origin? (Specify Cuben, Mexican, Puerto F		ck, White, etc.
I 21215-0 and within 72 ho system. we than "natur it, the Medical. Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	lifa. DO NOT us	rk done during most of working	g	usiness/Industry
1 213 list will tygions her tha nt, the	17. Father's Name (First, Middle, Last)	sale (1-40r 5+)	Esman	(First, Middle, Maiden Surnem	ctronics
yland muld be fil Mental H whental H whental H afte even	Max Gim	pel	Lillia		· ·
Mar d 2 sho th and 7 is me traum	19e. Informent's Name/Relationship (Type, Print) Phyllis (simpel)			Route Number, City or Town, North brook	
Ore, ns 1 an of Heat of Heat of Heat of Heat of Heat	20e. Method of Disposition Burial 2 Crametion 3 Removel from	20b. Place of Disposition (Ner	na of		City or Town, Stete
Itim	4 Donetion 5 Other (Specify) 21. Signeture of Funerel Service Licensee	Judean Meu	morial 6dus	2000 Olue	1
W FORES	1/2	Danzar 1170	Post ille Pi	g Memorial C	hapels, Inc.
	23e. Pert1. Enter the disease, or complications the shock, or haert failure. List only one cause of	et caused the deeth. Do not enter the mod	de of dying, such es cardiac or	respiratory errest,	Approximete Intervel Between Onset and Deeth
Physician /Medical Examiner	Immediate Cause (Fine) disease or condition	wer Gastroin	testinal ble	eed	20 days
ja ja	resulting in deeth)	Due to (or es a consequence of):			
8760, sata be executed hyssician and the burial-transit dical Examiner	Sequentiatly list conditions, if env. laading to immediate	Due to (or es e consequence of):	Y 3	15. 37. 15.	
68760, tificata be execuge physician and as the buntal-tra	Sequentially list conditions, if eny, laading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in deeth) Last	Due to (or es a consequence of):			
0 H 28 T	d				
. o o o	Pert II. Other algnificant conditions contributing to	death but not resulting in the underlying o	cause given in Pert I.	23b. Did tobacco usa co	ntributs to the cause of death?
E XD .	Renal fail	vre		1 □ Yes ⊅ No	3 Probably 4 Unknown
aw require the been seen seen seen seen seen seen see	Renal fail Aspiration	pneumonia	مباتين	24e. Wes en autopsy performed?	24b. Were eutopsy findings eveitable prior to completion of cause of deeth?
= F # 8 0				1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
F 5 5 0	25. Was casa rafarred to medical examiner? 1 Yes 2 No Hospitel:	Xtnpatient 2☐ ER/Outpatient 3☐ DC	26. Pleca of Deeth Other: 4 Nursing Hon	(Check only ona) ne 5□ Rasidenca 6 □Oth	ner (Specify)
After fune	Neturel 5 Pending (M	ta of Injury fonth, Day Year) 28b. Tima of Injury M	28c. Injury et 2 Work? 1 ☐ Yes 2 ☐ No	8d. Describe how injury occur	red
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be	ece of Injury - At home, ferm, street, fector, ilding, etc. (Specify)		8f. Location (Street and Numb City or Town, State)	ber or Rural Routa Number,
To the Hospital within 24 hours of the Funeral completely filled Medical Co.	(Check only 2 Medical Examiner: On the	the best of my knowledge, deeth occurred be basis of examination and/or investigation enner steted.	et the time, date and pleca, e , In my opinion, death occurre	and due to the cause(s) end mo	enner as stated and due to the cause(s)
To the within To the comple	29b. Signey and title of certifien	290	c. License number		d (Month, Day, Year)
3	, ()	30,10	D 43539		4/00
	30. Name and addrass of person who completed a Raymond M. White	L MD Holy Cros	is Hospital 1:	500 Forest Gla	n Rd.
State	31. Dete filed (Month, Day, Year) 32	Registrer's Signeture	who i		Silver Spring,

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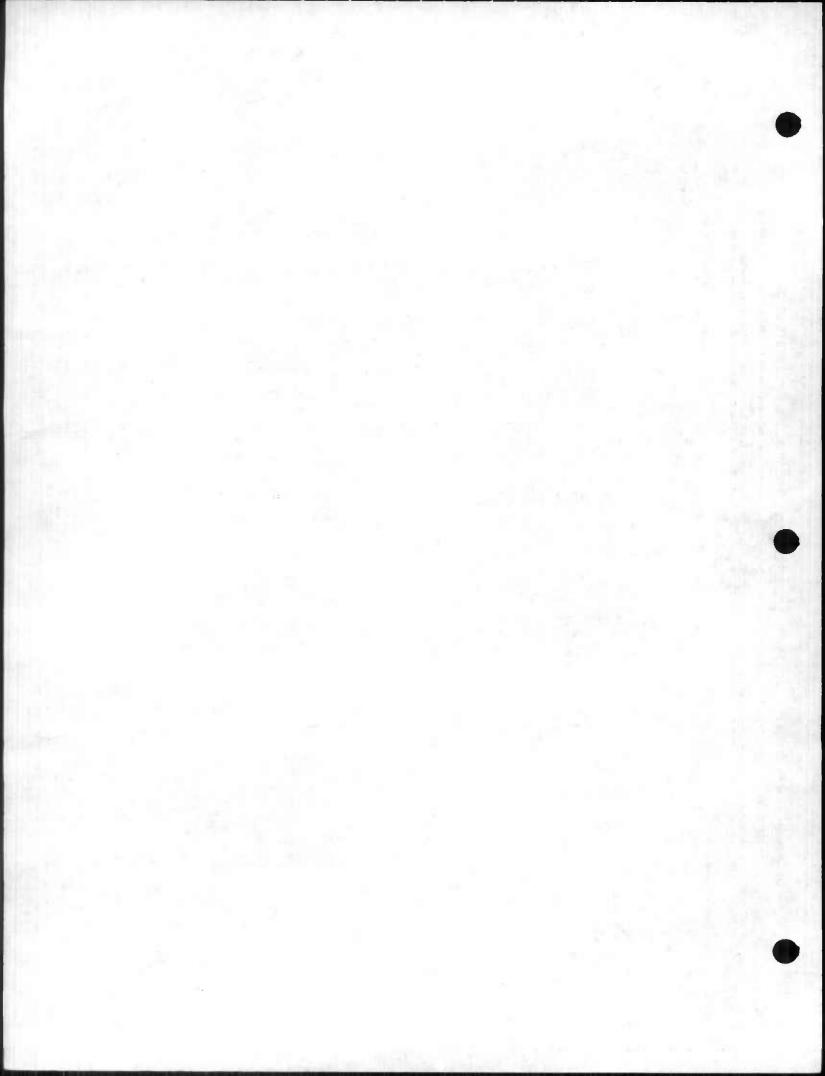
State of Maryland / Department of Health and Mental Hygien 37

						Ce	rtificat	e of	Death		Reg. No.	01	1 1 1	
		1. Decedent's Neme	(First, Middle, L	ast)						2. Dete of De Month	eth Dey	Year	3. Time of Dea	ath
	hysician /Medical	Lawerance	Gonsa	lves						Novembe	0 00		2:03 p	om
40.	Examiner	4a Fecility Name (If	not Institution, gi	ve street end num	nber)				4b. City, Town, or	Location of Deet	h 4c. County	of Deeth		
		Holy Cros	s Hospi	tal					Silver S	Spring	Montg	omery	r	
	neral ector	5. Sociel Security Nu N/A		Sex 1 M 2 □ F	7. Age (In yrs.	last birthday Yrs.	Months Months	1 Year Deys	Hours Min		th by, Year) 2000	Count	ace (Stete or Fo In) 1and	oreign
P		Usuel Residence of I	Decedent 10b. County		10c C	ity. Town or L	ocation					10	Od. Inside City L	imite
aryla	of participation of the partic												1 ☐ Yes 2	
he 7	ect of	Maryland 10e. Street and Num		ery	Roc	kville	10f. Zig	Codo			10g. Citizen of W	That Count		
th with	r items 23a or 28a-fe iner must be notified Funeral Director	14009 Lon		e				853			USA	met Court	tyr	
and 21215-0020 be filed within 72 hours after death with the Maryland tal Hygiene.	by by	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Wes Dece Armed For 1 Yes If Yes, Give Yeer or De	rces? 2 XNo e	J,S. 13.	Wes Deced If Yes, special 1 Yes		Hispenic Origin? (Sean, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Blec Specify	- America k, White, e	etc.	
2 2 2	te sa		15. Decedent's E	Education		16a. Dece	dent's Usu	el Occu	pation	41	16b. Kind of Bu	siness/Ind	lustry	
215 Fin 7	other than 'natura event, the Medical Be Completed	(Specify Elementary/Second	y only highest gi	College (1	-4or 5+)	life.	DO NOT u	rk done se retire	during most of wo d)	orking				
d 212 filed with Hygiene.	E E	0	July (0 12)	ounce (40.01,	N/A					N/A			
T E	vent Se O	17. Father's Neme (F	irst, Middle, Las	t)					18. Mother's Ne	me (First, Middle	, Maiden Sumam	e)		
Maryland od 2 should be file tith end Mental Hy	To E	Anthony F	. Gonsa	lves					Zita Je	orge				
aryla	E E	19e. Informent's Ner	ne/Reletionship	(Type, Print)		19b. Mall	ing Address	(Street	t end Number or F	lural Route Numb	er, City or Town,	Stete, Zip	Code)	
and 2	27 in	Anthony F	. Gonsa	lves / F	ather	1400	9 Lon	don	Lane, Ro	ckville	, MD 20	853		
Baltimore, Nemit. Pages 1 and Department of Health	1 2 2 T	20e. Method of Dispo 1X Burial 2 4 Donetion 5	Cremetion 3	□Removal from S	24.4.	Place of Disp cemetery, cre te of	emetory or o	ther ple	emetery	Dete 11/8/00	20c. Location - Silver			
Balti Permit. Depertm	Importal eny inju once.	21. Signeture of Fun		**		F	ranci	s J.	ess of Fecility Collins					
/Me Exam	physician end is the burial-transit and including the purial-transit and including the purial transit and including trans	Immediate Cause (F disease or condition resulting in deeth) Sequentially list condition, leading to limit	ditions,	. I	M M Due to (or es e conse	quence of):	te	7				Onset end Dee	
I Records, P.O. Box 68760, The lew requires that the death certificate be executed	Ç, 10	cause. Enter Underl Ceuse (Diseese or in thet Initieted events resulting In deeth) Le		d	Due to (or es e conse	quence of):							
deat	ed fo	Pert fl. Other signific	ant conditions	contributing to de	ath but not re	sulting In the	underlying o	euse gi	ven in Pert I.	23b. Dld	tobacco uss cor	ntributa to	the causs of d	leath?
, P.O.	be detach by Phy									10	Yss 2□ No	3 Prob	pably 4 Uni	known
Records,	2 should pieted									24e. Wes	en eutopsy ormed?	con	ore autopsy findi eilable prior to mpletion of ceus deeth?	
E	page OT									10	Yes 2X No	10	Yes 21 No	,
ta .	rector, pag	25. Wes case referre	d to medical						26. Place of De	eth (Check only	one)			
> yalol	al direc	exeminer?	lo	Hospitel: 1X Ir	npatient 2	ER/Outpatie	ent 3 DO	DA Ot	her: 4 Nursing	Home 5 ☐ Resi	idence 6 DOth	er (Specify	1)	
Vision of Vita Attending Physician: or deeth.	= 00	27. Manner of Deeth 1 Neturel 2 Accident	5 Pending		of Injury h, Day Year)	28b. Time (Injury	of 2	28c. Inju Wo	ry et ork?] Yes 2 ☐ No	28d. Describe	how injury occurr	ed		
DIVISION Of VITAI To the Hospital or Attending Physician: Within 24 hours efter deeth.	led in by the funeral Certification:	3 Suicide 4 Homicide	nome, farm, s	treet, factor	y, office		28f. Location (City or To	(Street and Numb wn, State)	er or Rure	Route Number	r,			
Hospita 24 hour	completely filled in Medical Cert	29e. Certifier (Check only one)	Cartifying P	hysician: To the miner: On the ba	sis of examin	owledge, dee etion end/or in	th occurred nvestigation	et the ti	ime, date end plea opinion, deeth occ	e, end due to the surred et the time,	ceuse(s) end me dete end plece, o	nner es ste and due to	eted. the ceuse(s)	
oth	Me omple	29b. Signature and fi	tle of certifie	\	^	Λ	29	c. Licen	se number	T	29d. Date #igned	smahin, i	Day, Year)	
HSH	- 0	> //C	700	MANTE	1///	//	T	13	5000		11/8	12	000	
		39 Neme end eddres	s of parson who	completed by	di deeth (Ite	m 23e) (Tyre	. Print)					1		
		YOU F	PI	ISTV	1. V).			- G1	en Road	Silva	Spring	MD	20010	
17	State	31. Dete filed (Month	, Day, Yeer)	32. Be	egistrer's Sign		1	G 1	/ NOAU	PITAGE	ohr mg.	ענויג	20710	
P	legistrar	NO	4 00 2	nnn A	queras	19.	400	Delle.	21					



State of Maryland / Department of Health and Mental Hygiene 00 37112

			Ce	ertificate	of L	Death		Reg. No.	J	1116
	1. Decedent's Neme (First, Middle, Last	1)		V-1			2. Dete of Dec		Ville	3. Time of Death
Physician	Theodore S. Gordo	on					Octobe	r 31, 20	Year 000	12:47 PM
/Medical Examiner	to English Name (Month textituding when		- 43		4	b. City, Town, o	r Location of Deeth			
Examiner	Washington Adven	tist Hospital			-	Takoma 1	Park	Montgo	0 m 0 2 T	7
Funeral	5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) If Under 1	Yeer	If Under 24 H	s. 8 Dete of Birt	h	9. Birthp	leca (Stete or Foreign stry)
Director	180-16-3580	XM 2□F 77	Yrs.	Months	Deys	Hours Mi	Jan. 3	0, 1923	Penr	nsylvania
Manual Ma	10e. Stete 10b. County	10c. Ci	ity, Town or L	ocation					1	0d. Inside City Limits
Varytas f show led at	Maryland Montgome	C.	lver S	nuina						1 X Yes 2 □ No
or zile-fr	10e. Street and Number	ery 31	IVEL 3	10f. Zip C	Code			10g. Citizen of W	het Cour	ntry?
		ighway			0910	0	1000	United		
her death there as 23 siner must	11. Merital Stetus	12. Wes Decedent Ever in U Armed Forces?	J,S. 13	Wes Decede	ent of Hi	spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Raca	- Americ	an Indian,
The and West of the Control of the American Control of the American Control of the Control of th		1 X Yes 2 No If Yes, Give Yeer or Detes: 1945.		1 ☐ Yes 2		Specify:	110411, 010.7	Specify:		
S to	15. Decedent's Edu	ucation	16a Dec	edent's Usual	Occupa	ation		16b. Kind of Bu	siness/Inc	dustry
ad within 72 ho rigions, ar than "natural, the Medical Completed	(Specify only highest grad Elementery/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)	luring most of w	onking			
A Paris		5+	Eng	ineer				Transpo		ion
Be even						18. Mother's N	ame (First, Middle,	Maiden Sumeme	B)	
Ment Ment To I	Rudolph N. Gordon					Eva S	cott			
and and	19a. Informent's Neme/Reletionship (T)	ype, Print)	19b. Mei	ling Address ((Street e	and Number or	Rural Route Numbe	er, City or Town,	State, Zip	Code)
	Theodore A. Miles	, brother-in-	law 2	115 Yo	rkto	own Rd.	N.W., Was	hington,	D.C.	20012
- TE6	20e. Method of Disposition	20b.	Plece of Disc	position (Neme	e of		Dete	20c. Location -		
Pages mit if the	1 ☐ Buriel 2 🕅 Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	Removel from State	. , .	ke Cre		,	11/4/00	Reltevi	1110	Maryland
in the same	21. Signature of Funeral Service Licens			22. Name end				DCTC3V	. IIIe,	naryland
P de la se	Damae Mc	give					ervice, I	nc.	1. D.	C.
	23a. Pert1. Enter the disease, or compositions, or heart failure. List only	lantions thet caused the dee	th. Do not e	nter the mode	of dying	g, such es card	ac or respiretory a	rest,	1	Approximete Interval Between
Physician	SHOOK, OF Healt failure. List offer o	Cause on each line.							1	Onset end Death
/Medical	Immediate Cause (Final	Thrombolio	Thuom	h		. D.,,,,,			1	
Examiner	diseese or condition resulting in deeth)	a. Thrombolic		-	peni	ic Purp	ıra	_	12	months
		Gastrointe	or es e cons		ina				1	
executed in and tal-transit		b			rug					months
death certificate be executed the action of for use as the burlat-transit sician/Medical Examir	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying		or es e cons							
ficate be expensed by the purish		c. Renal Insu							13	months
licate be physicle is the bu	resulting in death) Last	Due to (or es e conse	equence of):					1	
ding pl		d								
attending for use										
at the death ce by the attendietached for use	Pert II. Other significant conditions co	ntributing to death but not re-	sulting in the	underlying car	use give	en in Pert I.				the cause of death?
that the de detached detached							1 🗆	Yss 22 No	3 Pro	bably 4 Unknown
5 5 5						-		California	0.45 141	
been shoul			4					en eutopsy med?	av co	ere eutopsy findings eileble prior to empletion of cause deeth?
The law ate has page 2							10	Yes 2 No	1[∃Yes 2□ No
certificate rector, page						26 Place of F	Peeth (Check only o			
Physician: this certific ral director,	examiner?	Hospitel: Y Inpatient 2] 5D(0.4		Othe	ar:			(0)	u.
Physic this cal directly direc		28a. Dete of Injury	28b. Time	ent 3 DOA	4	4 LI Nursing	Home 5 Resident	now injury occurr		γ)
After funer	1 Neturel 5 □ Pending	(Month, Dey Year)	Injury	M	C. Injury	<br Yes 2□No				
Attending or death. After the fune fune fileation	2 Accident investigation 3 Suicide 6 Could not be	DO Division Albertain				163 2 110	79f Leasting /	Street end Number	or or Gun	of Bouto Number
to or Attending P is after death. In Oirector: After the funeration:	4 ☐ Homicide determined	28e. Pleca of Injury - At h building, etc. (Speci		treet, tectory,	omica		City or To	vn, Stete)	y or mure	ar Addie Mainber,
S S S S S S S S S S S S S S S S S S S		/								
To the Hoeptal or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification	29a. Certifier Certifying Phy (Check only 2 Medical Examinate)	on the basis of examination on the basis of examination on menner steted.								
Ne the				29c.	License	number		29d. Date signed	(Month,	Dey, Year)
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20	20 Nome of 111 1 1914	(WIV)	- 02-1 (-		000/	J4		Novembe	:г 1,	2000
	30. Neme and aderess of person who of							75		
	Thomas A. Bensinge	32 Registrer's Sign		nway Ce	ente	er Drive	e, Greenb	elt, Mar	ylan	d
State Registrar	NOV 6 6 200	1 Surve	B.	Spar	Ku					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Vear **Physician** Jack Junior Greene November 5 2000 11:30 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Mariner Health of Forest Hill Harford Forest Hill 8. Date of Birth (Month, Day, Year)
March 22, 1937 North Carolina If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. Birthplaca (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Months 63 Director 237-56-6814 Usual Rasidance of Decedant 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Vas 2 □ No MD Director N/A 28a-f Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Nerna 23s or 6108 Everall Ave 21206 United States Funeral 11 Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours aher each of Health and Mortal Hygiens.

Int if Nem 27 is marked other than "natural; or the any or other trainmals event, the Medical Examina 1 ☐ Yas 2 X No If Yes, Giva 1 Navar Married 2 Married 21215-0020 1 ☐ Yaa 2 ☒ No Specify: Specify: White py 3 ☐ Widowed 4 1 Divorced Yaar or Datas: Completed 16a. Decedent's Usuat Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Construction Worker Construction Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumame) Be Gordon Greene Ennice V. Tompkins 19b. Maiting Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6108 Everall Ave. Patricia Hunter / Niece Baltimore, MD 21206 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Department of Important: If any injury or Chesapeake Crematory, INC. 11/6/00 4 ☐ Donation 5 ☐ Othar (Specify) Beltsville. MD 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licenses CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286 23a-Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical tmmediate Cause (Final LTYC disaasa or condition rasulting in daath) hover concer Examiner Dua to (or as a consequenca of): Examiner or Attanding Physician: The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequença of): P.O. Box 68760, Physician/Medicai Dua to (or as a consequance of): US0 85 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? signed by the 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yas & No 1 Yas 2 No certificate funeral director, 25. Was case referred to medicat examinar? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edicai Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury st Work? After 5 Panding invastigation Neturel death. 1 Yas 2 No 2 Accidant To the Hospital or Attand within 24 hours after death To the Funeral Director. 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) in by 4 Homloide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signad (Month, Day, Year) November 6, 200 57 32 275 30. Neme and addrass of person who completed cause of deeth (Item 23a) (Type, Print) Bel Air, MD 21014 DAVID 5. 615 W. MAC

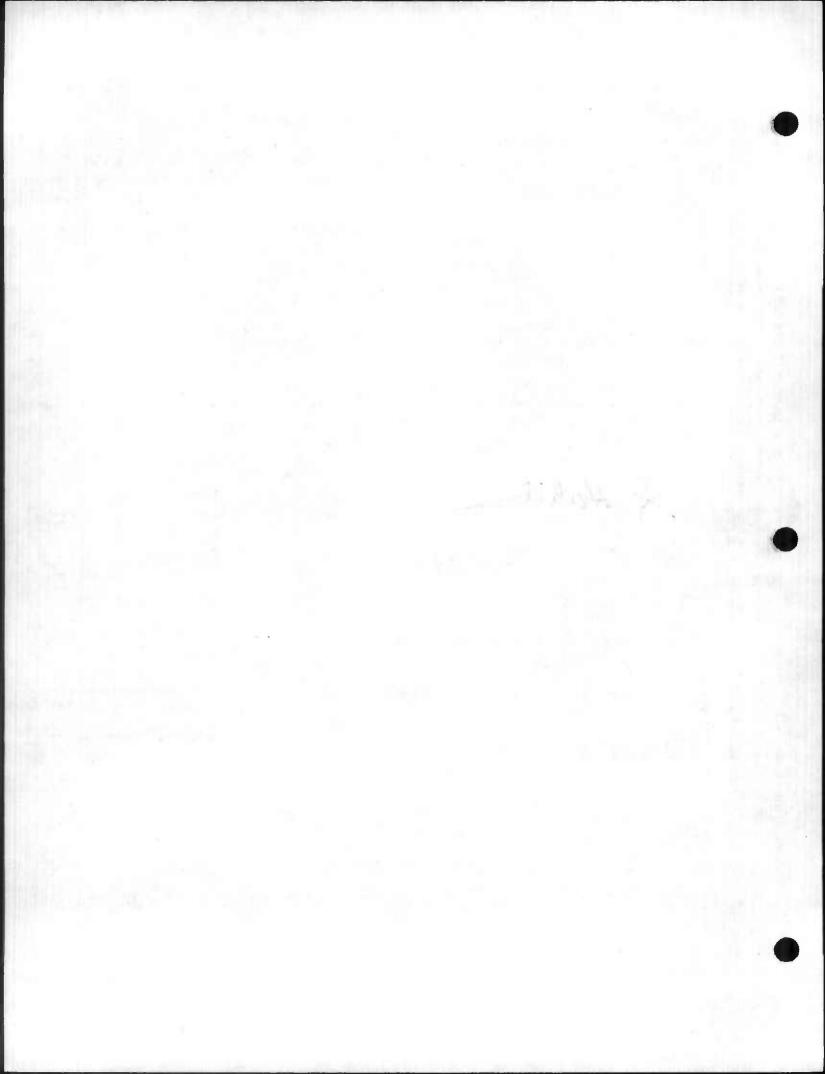
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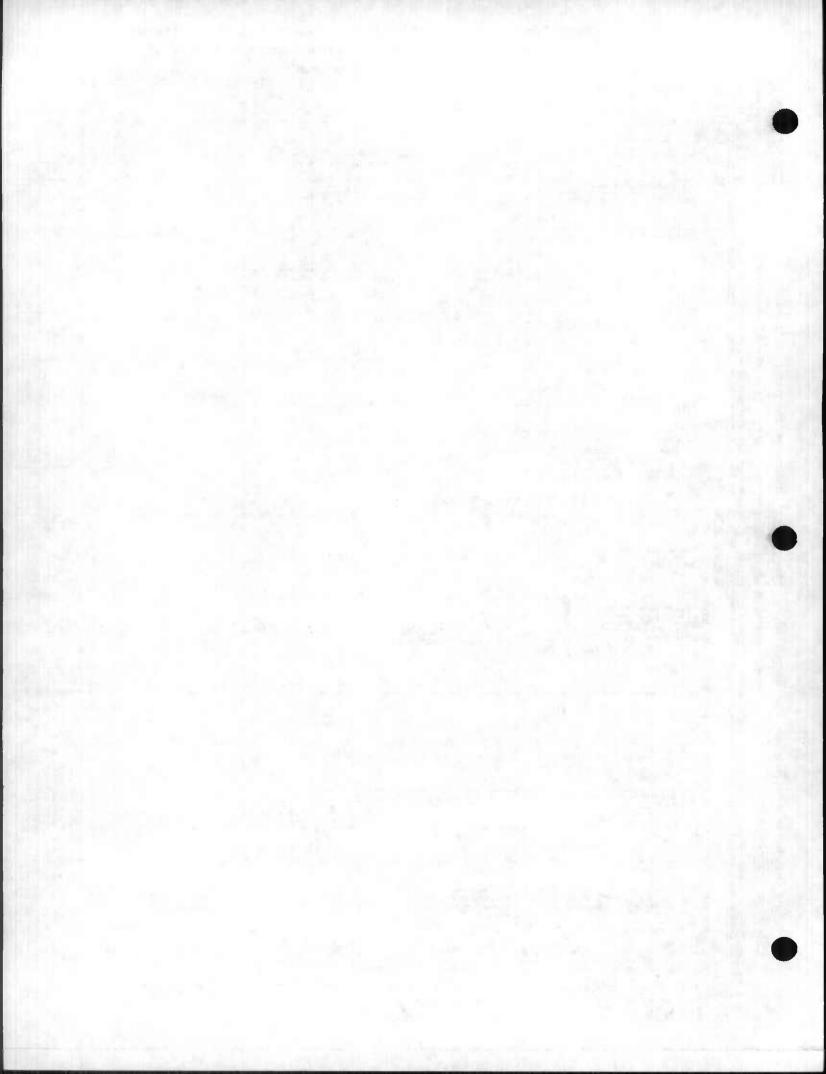
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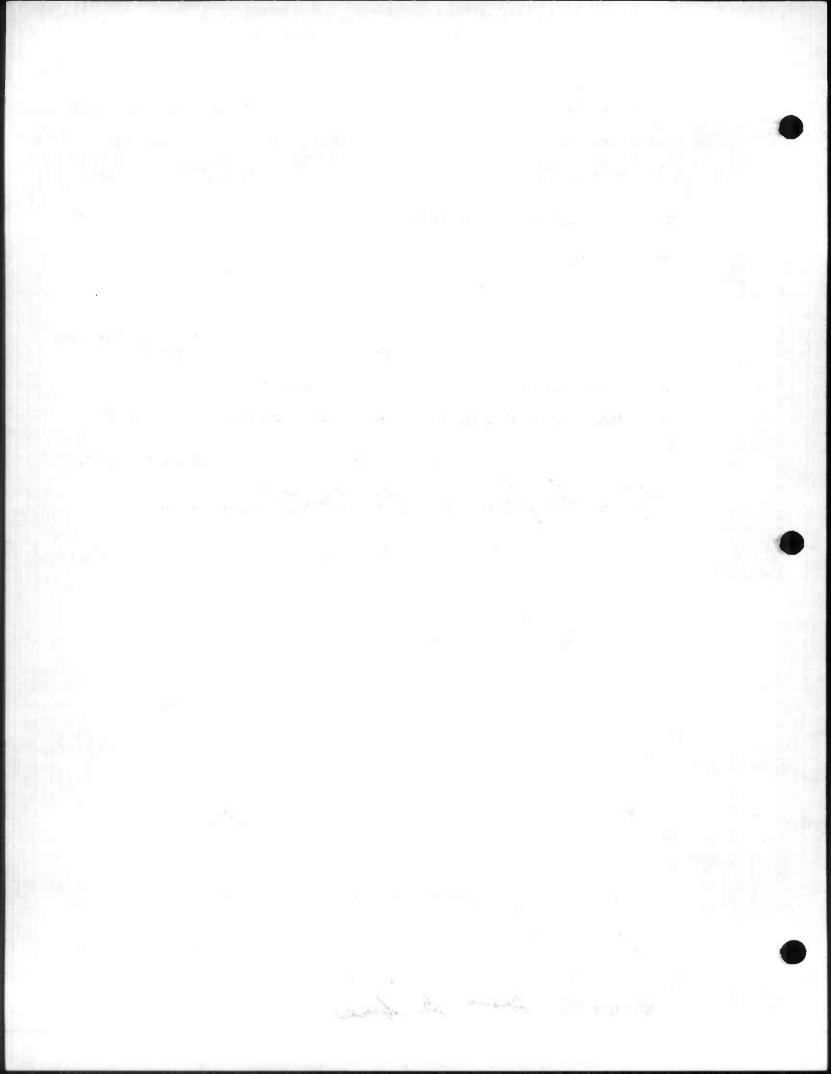
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Physician /Medical		Ethelmary	Honor	e¹			Novemb		000	1:45	
Examiner	4a Facility Name (If not institution, g	ive street and number)				4b. City, Town, o	Location of Deal		of Death		
	Sunrise Care &	Rehabilita	ation	Facility		E1kt	on		Ceci	11	
ineral rector	5. Social Security Number 167-28-5189	Sex 7. Age	e (In yrs. las 84	Yrs. If Und Month	er 1 Year Deys		(Month, D	rth ay, Year) .4,1916		plece (State or Fontry) chigan	
	Usual Residence of Decedent							,		6	
M M	10a. State 10b. County		10c. City,	Town or Location						10d. Inside City L	
notified rector	Pennsylvania	50.00	TULO		Phi	ladelphi	a			1 XYes 2	
be notified	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of	What Cou	ntry?	
	248 South 22nd S	treet			19	103		U	.S.A.		
iner mast	11. Meritel Stalus	12. Was Decedent E Armed Forces?	Ever in U,S.	13. Was Dec	cedent of I	Hispenic Origin? (an, Mexican, Pue	Specify Yes or No	0- 14. Rad	can Indian,		
ramine Samine by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced		No			Specify:	ito rican, etc.)	ican, etc.) Bleck, While, etc. Specify: Whit			
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r, the Medi	(Specify only highest g	rade completed)	(Give kind of work done during most of life. DO NOT use retired)				orking	7777			
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F O	17. Father's Name (First, Middle, Lat	st)			tist	18. Mother's Na	ame (First, Middle	Self-Employed A			
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ž.			20h Dia	531 Madi		Avenue,		20c. Location			
6	20e. Method of Disposition	☐Removal from State	cen	netery, crematory of	r other pla		Dete				
5		1 Burial 2 NiCremation 3 Removal from State 4 Donation 5 Other (Specify) Cemetery, crematory or other place) R.A. Ferris & Co., Inc. 11/10/00 West Chest									
E S	21. Signature of Funeral Service Lic	ensee		22. Name	and Addre	ess of Facility tterson	S Con F.	manal U	000	D A	
88	Showers In	truen 1	72 F						one,	I.A.	
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death.	Do not enter the m	ode of dyi	e, Maryl	ac or respiratory	errest,		Approximate	
cian	shock, or heart failure. List on	y one cause on each lin	ne.						i	Interval Between Onset and Dea	
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iner	disease or condition resulting in death)	a	men	101 0/ 40	zuei	wers y	pe			775	
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buris	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c. Pe	Reply	eral Va	asce	hocial	Usease		i	yrs	
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rector, page 2							10	Yes 2 No	1	☐ Yes 2☐ No	
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completely filled in by the funeral Medical Certification: 1	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exi	Physician: To the best of iminer: On the basis of and manner sta	examination	edge, death occurre n and/or investigation	ed at the ti	ime, date and plac opinion, death oc	ca, and due to the curred at the time	cause(s) end m , dete and placa,	anner as :	stated. to the cause(s)	
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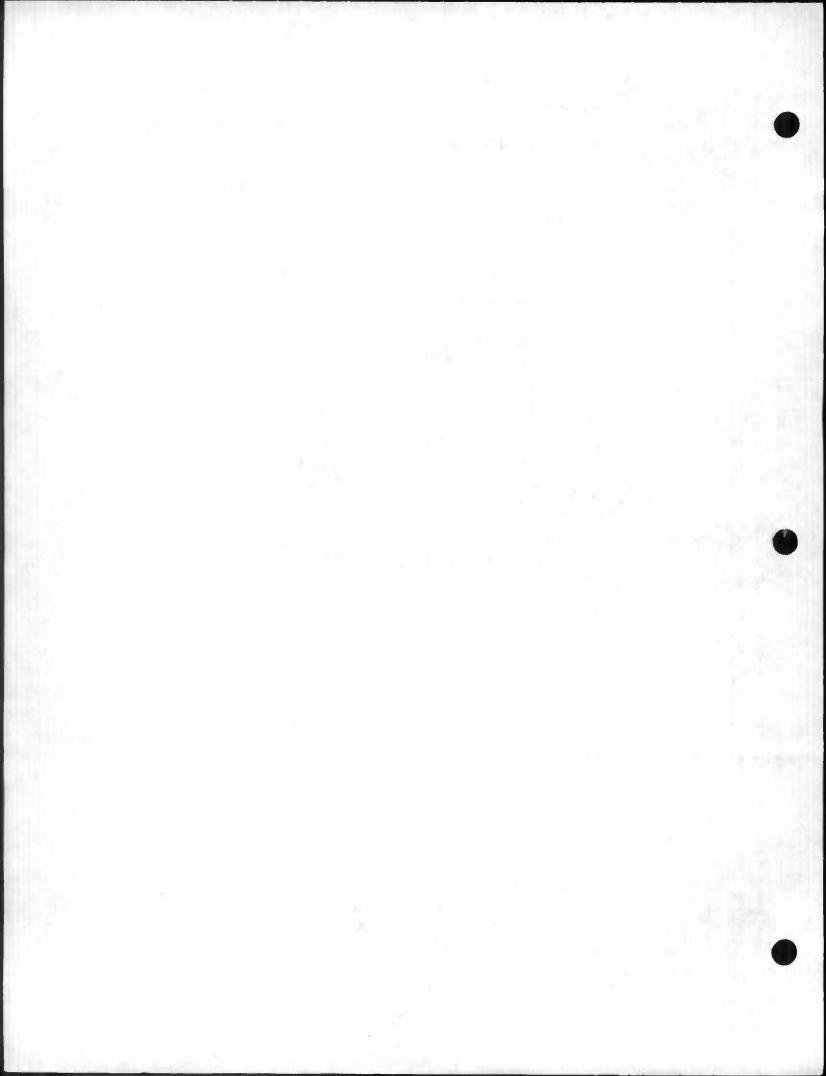
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aminer	40.	Facility Name (If not institution, go	ive street and number	r)			4b. City, Town, or		h 4c. County	of Death	
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al or			Sex 7. A 1 □ M 2 → F	ge (In yrs. le	ast birthdey) Yrs.	if Under 1 Ye Months Da			th ly, Yaar) 129	9. Birthplace (Country) Md.	Stata or Foraign
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	19	a. Informant's Name/Relationship Alfred Strayer I		sband		-	eet end Number or F Street Po)
	20€	e. Method of Disposition		00	ace of Dispos	sition (Name or netory or other	f place)	Dete	20c. Location -	City or Town, S	tate
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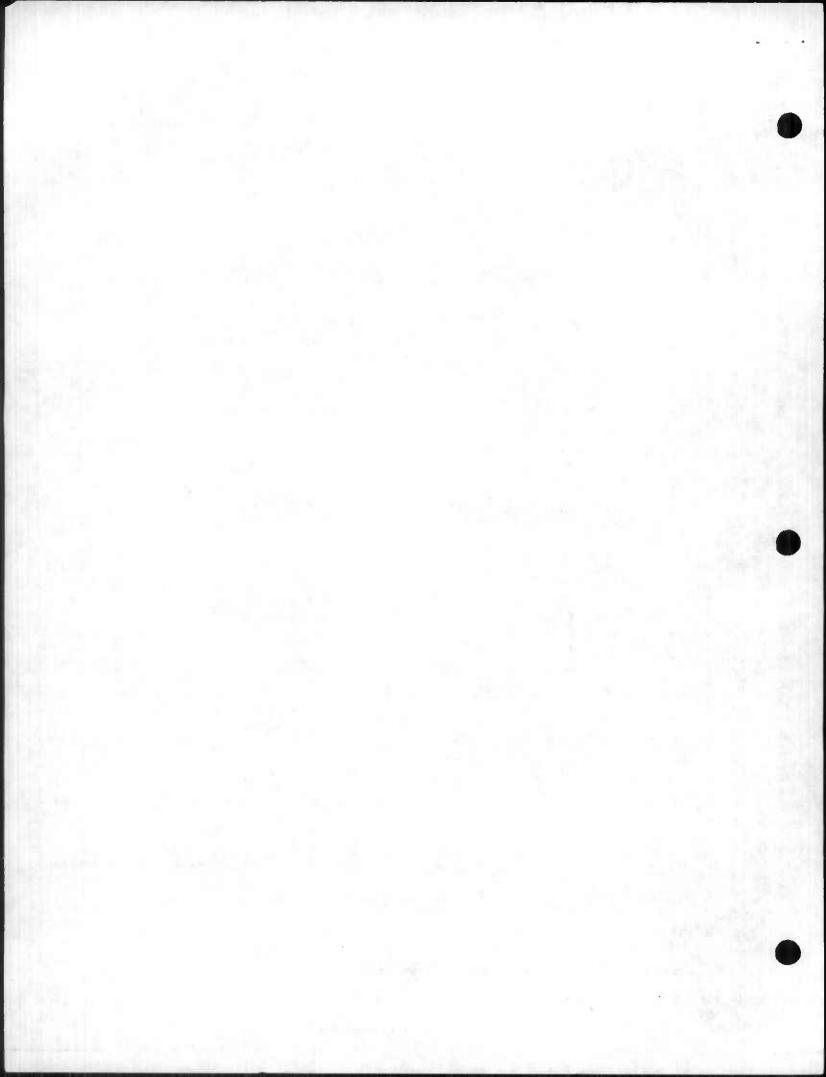
Department of Health and Men	tal Hygiene	nn	37	1	1
Certificate of Death	Reg. No.		0 1	-	1

	1. Decedent's Ne	Decedent's Neme (First, Middle, Last)									2. Dat	e of Dee	th Day		Yeer	3. Time	of Deeth
Physician /Medical	TIMOTHY	ALVIN H	HOOD									tobe:				08:	11 A.
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o a a de	Certification:															
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by												and due to the				
PHC 24 Fu letel	edical	(Check only 2 Medical one)	Examin	er: On the b	asis of ex	amination and	1/or inves	stigation, in	my op	inion, dea	th occur	red at the time	, data and pla	ice, and d	ue to tha o	cause(s)
To the within 2.	Me	29b. Signatura and title of condition	1	//	11	11 1		29c. L	icense	number			29d. Date s	igned (Mc	onth, Day,	Year)
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		30. Name and address of person	n who oo	mpleted caus	se of deat	h (Item 23a) (ype, Pr	rint)	001	0				00		
		Coho Mi-al-i-	N/ID				1					icute A	ve #1	00		
Stat		Gabe Mirkin, 31. Date filed (Month, Day, Year	MD_	32, F	Registrer's	Signature	Ken	singto	on,	MC Z	:089					
Stat Registra		NOV OF	2000		new-a			door	61							

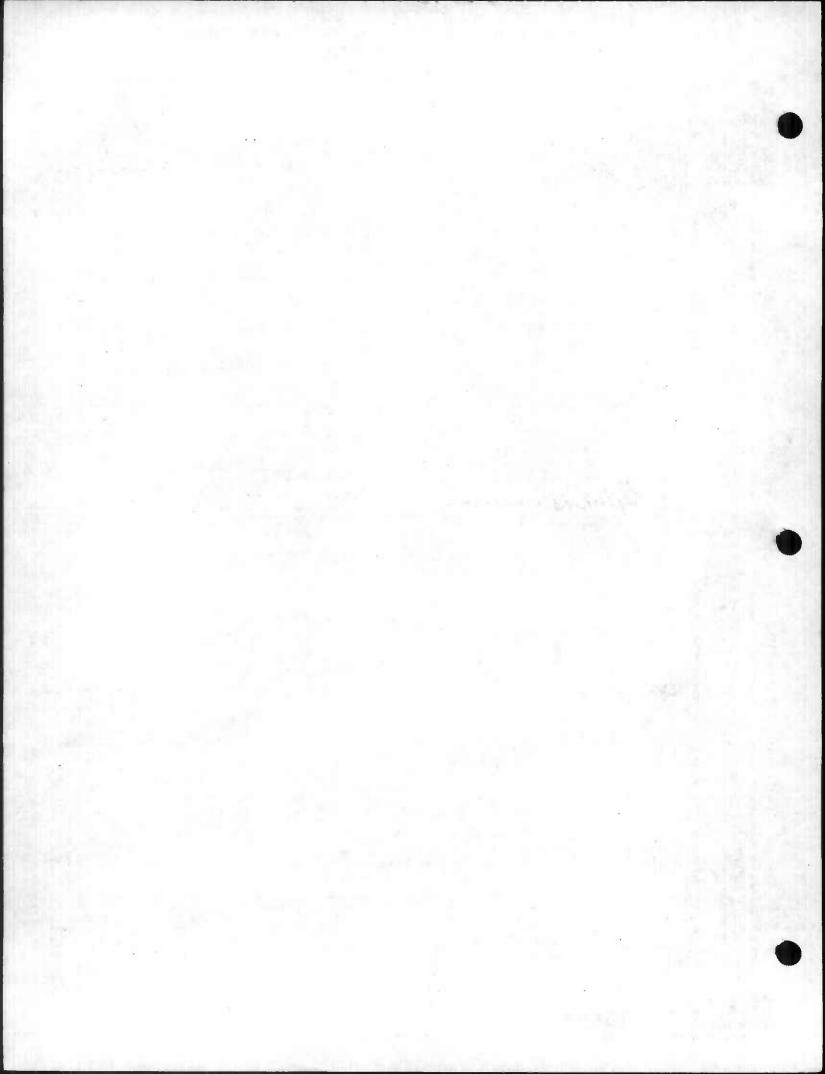


A by Series By S	1. Decedent's Name (First, Middle Florence Is Facility Name (If not institution, 6817 Carlynn Ct 5. Social Security Number 181–10–7957 Usual Residence of Decedent 10b. County Maryland Montg 10e. Street and Number 6817 Carlynn Ct 11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highes Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Left Fred 19a. Informant's Name/Relationsh Lois Finley / D	F. give street and number 6. Sex 1 M 2 F 7. A 1 M 2 F 7. A 1 Wes Decedent Armed Forces 1 Yes 2 F 1 Yes, Give Yeer or Deles: 5 Education to grade completed) College (1-4 or	ge (In yrs. lest. 84 10c. City, To	own or Location Bethe	esda le 20817 of Hispanic Origin? (Scuban, Mexican, Puert	a. Date of Birth (Month, Day Jan. 15	Day oer 6, 20 4c. County Mon h, Year) 5, 1916 10g. Citizen of W	of Death tgomery 9. Birthplace (State or Country) Pennsylvan: 10d. Inside City 1 Yes 2 That Country? States 3. American Indian, k, White, etc.
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4 20 00	Lois Finley / D		1	9b. Mailing Address (Str				
252		aughter	non olean	6817 Carly				0817
520	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □Removal from State	como	of Disposition (Name of stery, crematory or other	place)	Nov. 8	20c. Location	City or Town, State
25	4 ☐ Donation 5 ☐ Other (Sp	ecify)	Chesa	apeake Crema	atory Inc	2000	Belts	sville, MD
moortant: If	21. Signature of Funeral Recycle L	icensee		22. Name and Ac Rapp Fi	dress of Facility ineral and n D. Lohrm	Cremati	on Serv	ices
2529	Stephen	Munan		Stephen	n D. Lohrm	ann P.A.	ring M	20910
taminer of	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Cong	cestive Due to (or as	Heart Fails a consequence of):	ure			Interval Betwonset and De
a la		b. Mitr		uritation				1
burletransit burletransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Come		a consequence of):	7.0			1
bur de	Cause (Disease or injury that initiated events	c		rtery Diseas	s e			
attending physical for use as the teleform/Medice	resulting in death) Last	10 m 10 m 10	Due to (or es	e consequence of):				
nding 1880		d						
I for	Ont II Other elevitions and disease	an anatalbutine to don't	hut not sometio		niven in Cont I	non Did t	lahassa usa sar	ntribute to the cause of
be detached for use as the by Physician/Medic	Part II. Other significant condition	us continuiting to death.	out not resulting	g in the underlying cause	gwen in Pen I.		Yes 2∏ No	3 Probably 4 U
s been s 2 should pleted		100					an autopsy rmed?	24b. Were autopsy fir available prior to completion of ca of death?
certificate har rector, page						101	Yes 2∏ No	1 🗆 Yes 2 🗆 t
Be 5	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	one)	
90 2	examiner? 1 ☐ Yes 2 🖾 No	Hospital:	ient 2 ER/	Outpatient 3 DOA	Other: 4 Nursing H	lome 5 🕅 Resid	denca 8 Oth	er (Specify)
the series	27. Manner of Death 1 Matural 5 Pending 2 Accident investig	28a. Date of Inj (Month, D			njury at Work? 1 🗌 Yes 2 🗎 No	28d. Describe t	how injury occuri	red
rs after death. I Director: After to ed in by the funer: Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 289. Place of it	njury - At home, etc. (Specify)	, farm, street, fectory, off	ice	28f. Location (S City or Tox	Street and Numb wn, State)	er or Rural Route Numb
3 6 -			of examination	ige, death occurred at the and/or investigation, in r				
To the	29b. Signature and title of certifier	~ .		29c. Lic	ense number		29d. Date signer	d (Month, Day, Year)
	15-8)>(com		M	D40576		Novem	ber 7, 2000

Registrar

State 31. Date filed (Month, Day, Year) NOV 0 9 2000

Sporks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** NOV. 6, 2000 DOROTHY A. HILL 3:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 501 Main Street #122 Laurel PRINCE GEORGES Hunder 24 Hrs. 8. Date of Birth Month, Day, Year) 18 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar 9. Birthplaca (Stata or Foreign **Funeral** Months Days 1DM XDF Maryland 82 Director 214-16-7453 the Meryland 10e State 10d. Inside City Limits 10b. County 10c. City. Town or Location "natural", or flams 23s or 28s-f show X□ Yas 2□ No Director Prince Georges MD Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 501 Main Street, #122 20707 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status pemit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than "natural", or free eny injury or other treumatic avent, the Medical Eventine Pance. Black, Whita, atc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Black 1 Yes 2X No Specify: Specify: à 3 DWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home 7th Housewife 18 Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) 8 Carrie Born Dorsey Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20905 14735 Good Hope Rd., Silver Spring, MD 19a. Informant's Name/Relationship (Type, Print) Mable E. Walker (Sister) 20a. Method of Disposition 20b. Place of Disposition (Nama of cametery, crematory or other place) Dete 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 11/13/00 Sandy Spring, MD Ash Memorial Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liceon 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 Olle 23a. Part1. Enter the expense or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** myo cardial infarction. /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner physicien end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of):

Physician/Medical þ Completed 8 Certification: To

Records, P.O.

Division of Vital Attanding Physician:

this After this

within 24 hours after death.

To the Funeral Director: After dompletely filled in by the fun.

7

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Colorectal cancer. chronic obstructive palmanarydisease 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one)

23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown 1 Yes

24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yas 1 ☐Yas 2 ☐ No

1 Yes 2 No 27. Manner of Death Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 Tyes 2 No 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

lali, MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

State

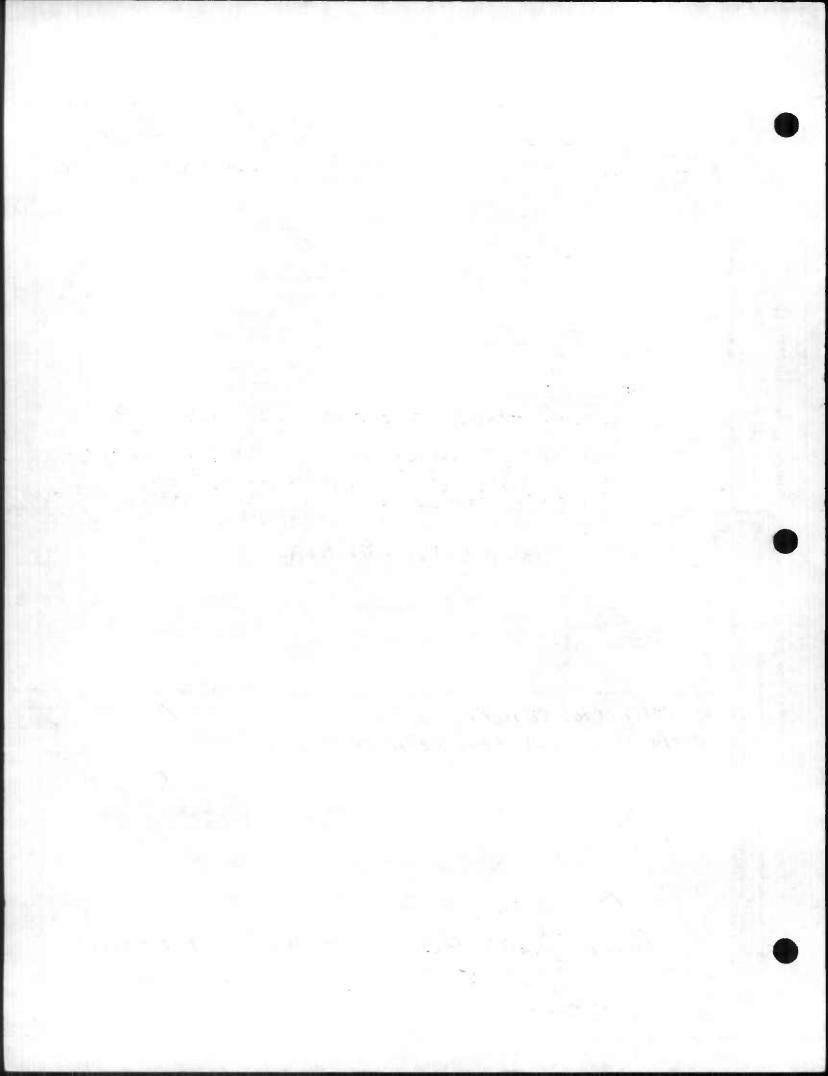
Medical

31. Data filed (Month, Day, Year)

NOV 6 9 2000

Reuna Jalali, M.D. 7350 Van Dusen Rd., Suite 130, Laurel, MD 20707 32 Registrar's Signature Comme

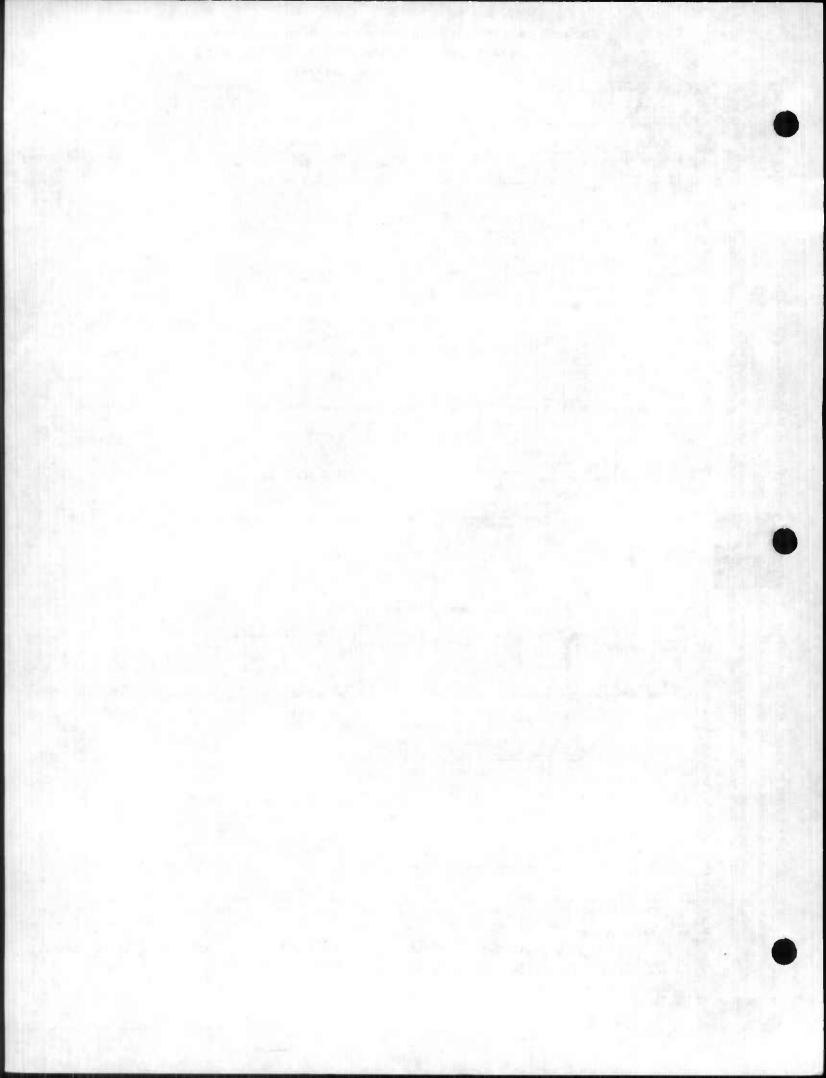
Registrar



Certificate of Death Reg. R		01160	1
State of Maryland / Department of Health and Mental Hygien	ne nn	37120	1

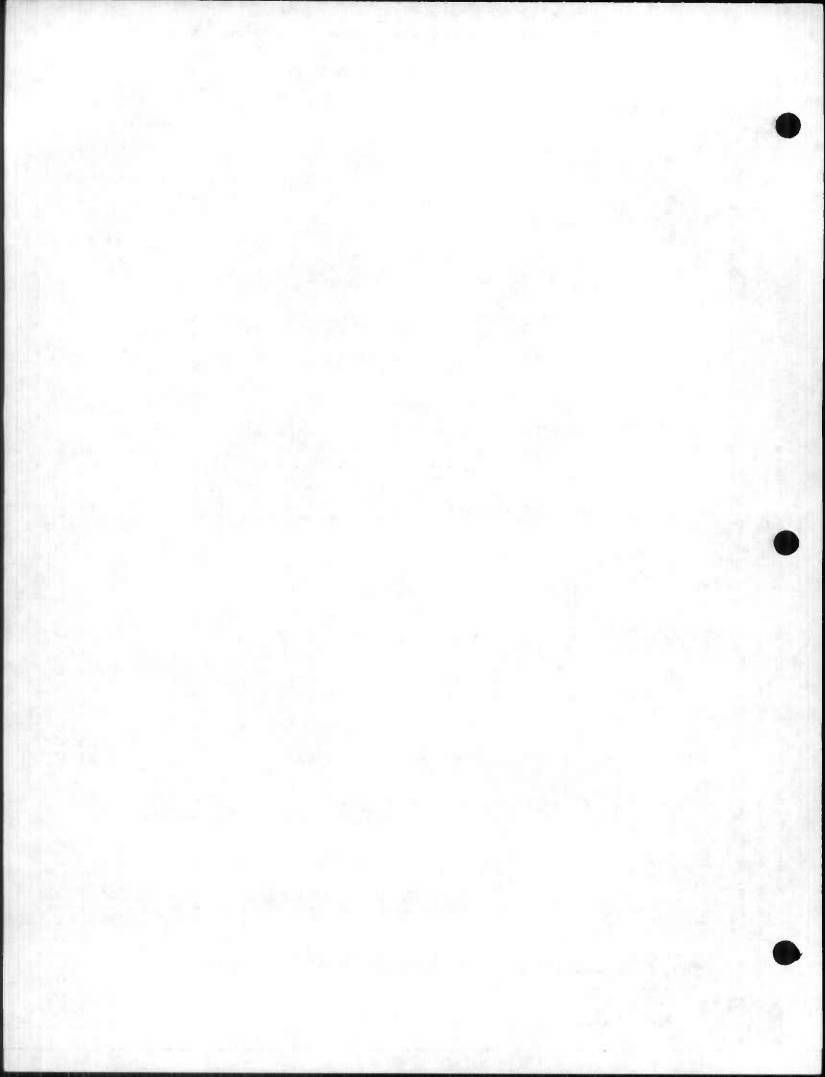
					Certi	ficate of	Death	,	Reg. No.	0	1120	
	B11-1	1. Decedent's Neme (First, Middle, L	ast)				NOTE OF			(ear	3. Time of Death	
0	Physician /Medical	Ralph Lee Ho	rnbake								10:45 PM	
	Examiner	4e Fecility Neme (If not institution, g	ve street and number)				4b. City, Town, or L	Annor Location of Deeth 111e Montgome	Death			
		Casey House								omer	y	
	Funeral	Sociel Security Number 6.	Sex 7. Ag	e (In yrs. last b	N			8. Dete of Birt (Month, Da)	(, Year)		ace (State or Foreign	
	Director	281-22-1374	TIZEM ZUF	87	Yrs.			Dec. 18	3, 1912 F	enns	ýlvania	
	g	Usual Residence of Decedent 10a, Stete 10b, County		10c. City. To	wn or Locat	tion	70.00			10	d. Inside City Limits	
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	her death r Neme 23 sizer must Funeral	11. Merital Stetus	12. Wes Decedent	Ever in U.S.	13. Wa			pecify Yes or No-				
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yla	Mem Man	Ralph Hornbake										
far	S S S S S S S S S S S S S S S S S S S	19e. Informant's Neme/Relationship			_							
	and		-Angier/Dau			,	House Ro					
ore	M Har	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3	☐Removel from State	20b. Plece camer	of Dispositi ery, cremet	ion (Neme of tory or other ple			20c. Location - C	ity or Tov	vn, State	
E	Part Hard	4 Donation 5 Other (Spec		Fort								
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		23a. Pert1. Enter the disease or con	nplications that caused	the deeth. Do							Approximate	
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	/Medical	Immediate Cause (Final disease or condition	Cong	estive	Heart	Failur	e			1		
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-	the ship	Pert II. Other eignificant conditions	contributing to death b	ut not resulting	in the unde	erlying cause gi	ven in Part I.	23b. Did	23b. Did tobacco use contribute to the cause of de			
	d by detac	Coronary Artery	Disease					10	Yes 2 No	3 Prob	ably 4⊠ Unknown	
ds,	8 88 0							Ode Mee		24h Wa	ere autopsy findings	
0	The law requin sate has been s page 2 should Completed	Aortic Valve Re	placement			2. Date of Death Month Day November 1, November 1, November 1, November 1, November 1, November 1, 4b. City, Town, or Location of Deeth Rockville Month Day Year Month, Day Year Dec. 18, 19 10 10 10 10 10 10 10	med?	sva.	nilable prior to			
Sec	hes the se and mps									of d	death?	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Sag.							10	res 2 ☑ No	1 🗆	Yes 210 No	
	clan: ector Be	25. Was case referred to medicel examiner?	Hospital.			~		th (Check only o	ne)			
of	2 00 7	1 ☐ Yes 2 ☒ No	Hospital:			3LI DOA	4 Li Nursing H) Hospice	
E C	Ing F After funer fon:	27. Menner of Death 1 ☑Neturel 5 ☐ Pending	28a. Dete of Inju (Month, De	y Year)	. Time of Injury			280. Describe i	low injury occurre	u		
Sign	tor: the	2 Accident Investigati	he	At home	form steed		165 2 100	291 Location (Street and Mumba	or Rural	I Route Number	
N N	tal or Attending P is after death. al Director: After tied in by the funere Certification:	4 ☐ Homicide determine	building, et	c. (Specify)	iami, street	i, rectory, office		City or Tox	vn, Stele)	OF FIDE	rioute riumber,	
	peral filled	29e. Certifier 1XX Certifying P	hyelcien: To the hest	of my knowledg	ne death or	ocurred at the ti	me, date and place	and due to the	couse(s) and man	ner es st	ated	
	n 24 hour n 24 hour n Funer pletely fil			f examinetion e								
-	outh outh	29b. Signature end title of certifier				29c. Licen	se number		29d. Date signed	(Month, L	Dey, Year)	
		Ann	ennen	n	9	01	5046	- /	Vovemb	er 2	2, 2000	
	(0	30. Name and eddress of person who	completed cause of d	eath (Item 23s	(Type Pri						(
		Steven J. Newman					Lage Ave.	Montgo	mery Vil	lage	, MD 20886	
	State	31. Dete filed (Month, Dey, Year)	32. Registr	ar's Signature		1						
	Registrar	NOV 0 6 2	000 Arene	va /	Ø. ,	Spork.						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 37121

			C	ertificate of	Death		Reg. No.	0 01161				
	1. Decedent's Name (First, Middle, L.	nst)				Death		th				
Physicia:	Tohn Tocomb The	SZ						17 7/1	4.H			
/Medica Examine	As Facilities Name of the sale		4b. City, Tow									
	Continuum Care	at Sykesville			Sykes	ville	Carr	011				
Funeral		Sex 7. Age (In y	rs. last birthda			4 Hrs. 8. Date of E	Birth Day, Year)	Birthplace (State or For Country)	eign			
Director	149-16-1842	74	Yrs.					New Jersey				
ž	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or	Sykesville Carroll Ca	10d. Inside City Lir	nits						
Vary f aho	Maryland Carroll	Sv	kesvil	٦٥	4b. City, Town, or Low Sykesvil.							
or 28s-f s be notified	10e. Street and Number	. 01	ACD VII	-			10g. Citizen of V	What Country?	o 7, 20 A.M. eath I. Birthplace (State or Foreign Country) W Jersey 10d. Inside City Limits 12 Yes 2 No Country? ates merican Indian, thite, etc. White ss/Industry Hauling e. Zip Code) 21157 or Town, State Ster, PA and 21921 Approximate intervat Between Onset and Death Onset and Death Approximate intervat Between Onset and Death Approximate interval Between Onset and Death A			
		nue					United	States				
ther death in the there 23 diner must	11. Meritet Status	12. Was Decedeni Ever in		3. Was Decedent of	Hispanic Orig	in? (Specify Yes or h	No- 14. Rac	e - American Indian,				
		1 X Yes 2 ☐ No	944 to			Puerto Hican, etc.)						
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes: 1	946	1 Tes 2M No	Specify:		Specify	White				
72 h	15. Decedent's E (Specify only highest gi	ducation ade completed)	/Gi	ve kind of work done	during most	ol working	16b. Kind of Br	usiness/Industry				
Man Pan	15. Decedent's E (Specify only highest gi Etementary/Secondary (0-12)	Cottege (1-4or 5+)			ed)							
	7 17. Father's Name (First, Middle, Las	<u> </u>	Truc	ck Driver	18 Mother	's Name /First Midd	Freight Hauli					
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d Ma	19a. Informant's Name/Relationship	(Type Print)	10h 14a	iling Address (Stree			ther City or Tour	State Zin Code				
trau	Gail Jones/Guard:											
Pages 1 annert of Heat int: If Nem 2 kry or other	20a. Method of Disposition		. Place of Dis	position (Name of			-					
Pages ant of nt: If it	1 Buriel 2 Cremetion 3 4 Donation 5 Other (Spec					11/10/0	O Most C	hootox DA				
artm ortan	21. Signature of Funeral Service side				-		y west c	nester, FA				
Page 18	Hicks Home for Funerals, P.A.											
	22 mm znam the diagona, or complications that counted the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate											
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/Medical	Immediate Cause (Final Alzheimers Dementin 1941											
Examiner	resulting in death)											
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Attending or death. ector: After by the fune	2 Accident investigation 3 Suicide 6 Could not	00 - Dian - (lain - A	t home form				(Street and Numl	her or Rural Route Number				
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral second se		hveician: To the best of my	cnowledge de	ath occurred at the t	ime date acc	Injace and due to the	ne causels) and m	annar as stated				
To the Hospital within 24 hours To the Funeral completely filled	(Check only 2 Medical Exa	miner: On the basis of exam and manner stated.	ination and/or	investigation, in my	opinion, deat	h occurred at the tim	e, date and placa,	and due to the cause(s)				
of the complete compl	29b. Signature end little of certifier	and manner desired.		29c. Licen	se number		29d. Date signe	d (Month, Day, Year)				
⊢≤⊢ő	Posts J.	Man 1	UD	0	328	82	11/2	1/00				
2.1.11	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
3+11/	Roh 1 6. N	1-017 114	Bus	かってり	Cent	- D.	Reista	Hown, Will	2117			
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	/								
Registra	11011 0 0 2000	Benery 1	9. d.	oouts								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Duplica tE Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Edward Christian Irwin 11, October 2000 11:39A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. 5. Social Security Number If Under 1 Yeer 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□ F Months Hours 291-10-2127 Yrs. 93 July 23, 1907 Director Indiana Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hame 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Frederick Walkersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Peges 1 end 2 should be filed within 72 hours after death to Department of Health and Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or farme 23a any Injury or other traumatic avant, the Medical Examples 23a any Injury or other traumatic avant, the Medical Examples 23a. 21793 9903 Foxhound Court United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Merital Stetus 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Metal Finisher Manufacturer 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Newton Irwin 2 Julia Crescencia Reich 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sue Seyler Daughter 9903 Foxhound Court, Walkersville, Maryland 20b. Place of Disposition (Neme of cemetery, cremetery or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Miami Valley Mem. Gardens 10/16/00 Springboro, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P. A. 40 Fulton Avenue, Walkersville, Maryland 21793 ymoul C erres 23a. Partt. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock or haart failure. List only ona cause on each lina. Onsat and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical subdural hematoma day Examiner Due to (or as e consequence of): Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been signed by þ 8 page 2 should Completed Be 2 Certification:

Division of Vital Records, P.O. Box 68760, Hospital or Attanding Physician: 24 hours effer death. Puneral Director: Affer this certificately filled in by the funeral director; g

Baltimore, Maryland 21215-0020

within 24 hours of To the Funeral C

Alexander					24a. Was an autopsy performed?	available prior to complation of cause of death?
					1 ☐ Yes 2 🖾 No	1 ☐ Yes 2 ☑ No
25. Was case referred to medi	Mospital:					
examiner? 1 ☐ Yes 2 ☒ No	Hospita	al: 1 Inpatient 2	ER/Outpatiant 3	DOA Othar: 4 Nursing	Home 5 ☐ Residanca 6 ☐ Oth	ner (Specify)
2 LI ACCIDATIO	ding stigation	. Date of tnjury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Cou 4 Homicide	Id not be ermined 286	b. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact fy)	ory, offica	28f. Location (Street and Numb City or Town, Stele)	ber or Rurel Route Number,
	at Examiner: O				ca, and due to tha causa(s) and mocurred at the time, date and placa,	

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D54619

10/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Winters

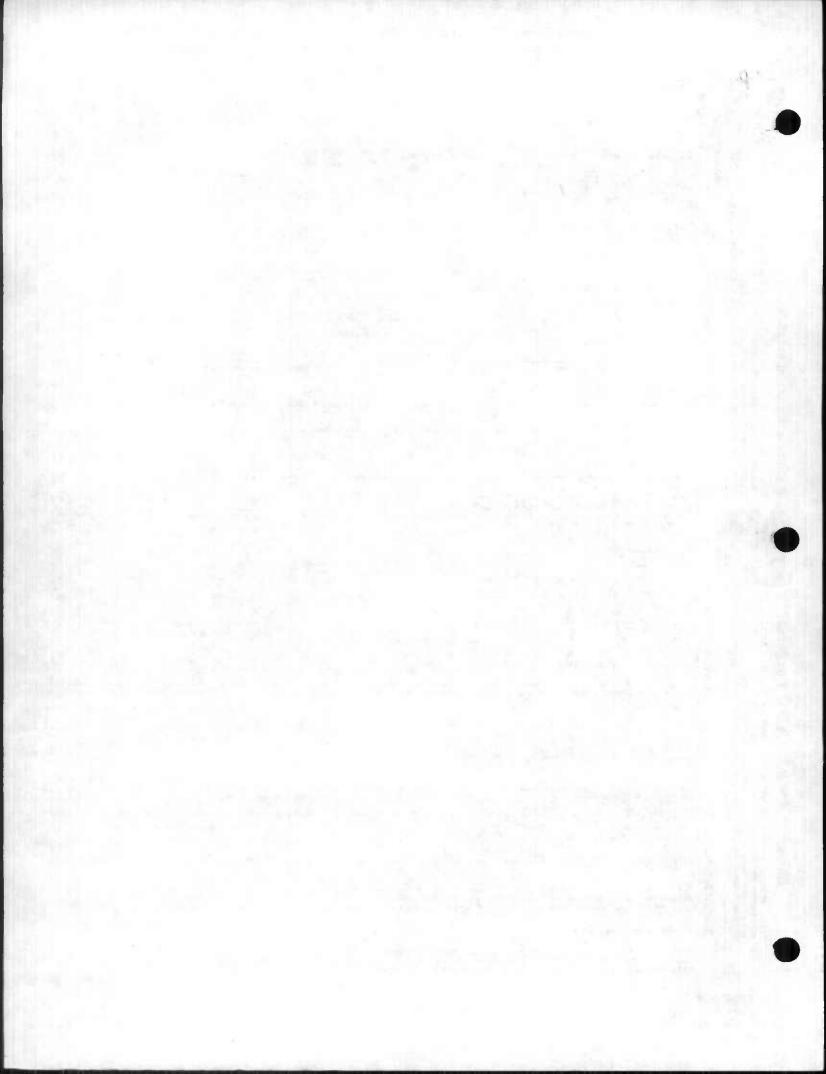
198 Thomas Johnson Drive, Frederick, Maryland

State Registrar

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31. Date filed (Month, Day, Year) 2 2 2000

32. Registrar's Signature

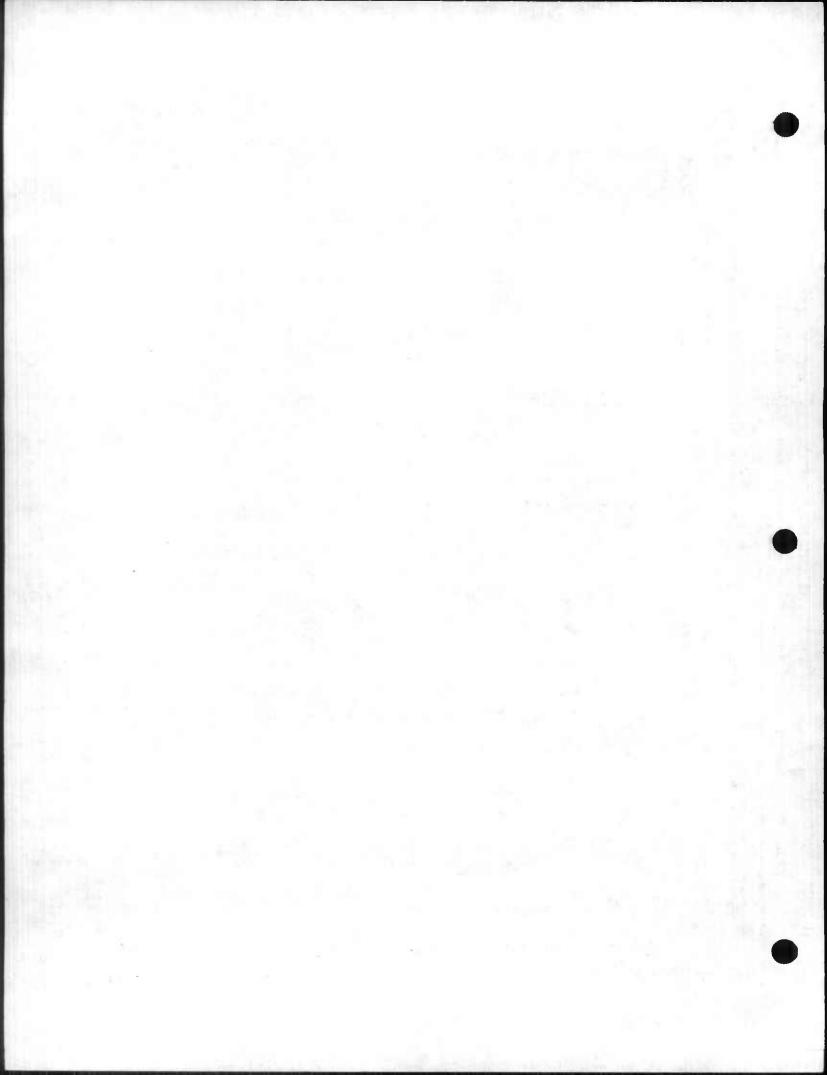


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

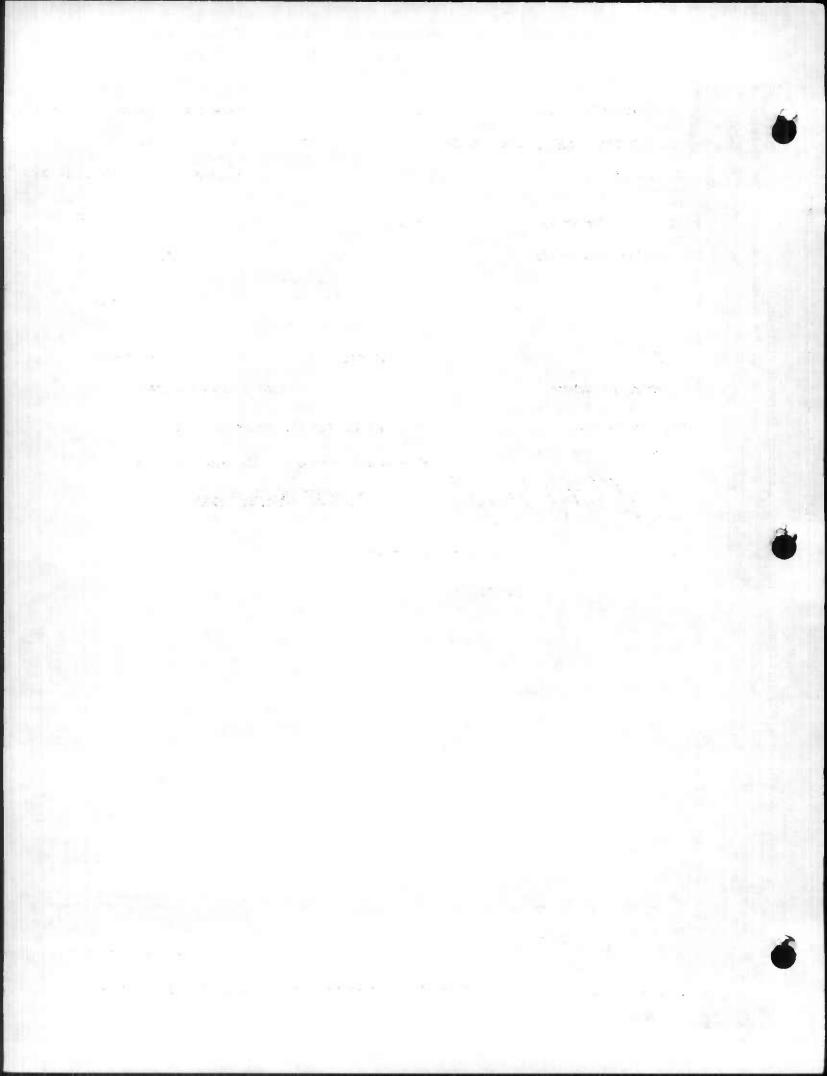
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	Examiner	4a Facility Nama (If not institu	tion, giva street and nur	n <i>ber)</i>			4b. City, Town, o	or Location of Dear	th 4c. Count	y of Death				
		Harford Memor	ial Hospita	al			Havre de	Grace	На	rford				
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) ;	altimore, mit. Pages 1 a partment of Her portant: if item y injury or othe	20a. Mathod of Disposition		20b. I	Place of Dispo	osition (Nama of matory or other pl	(aca)	Date	20c. Location	- City or To	own, Stata			
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-2 1		230 Part Enter the disease	or complications that o	arread the deet						, MD	Z10/8 Approximata			
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	Phys rithis aral dia	27. Manner of Death	28a. Data	of Injury	28b. Tima o		jury at	28d. Describe	how injury occu	rred				
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	or An Direct Jin by	4 ☐ Homicide dete	ermined 20a. Place	of Injury - At h	ioma, farm, st No	reel, factory, office	е	281. Location City or To	(Street and Num own, State)	ber or Hur	al Houta Number,			
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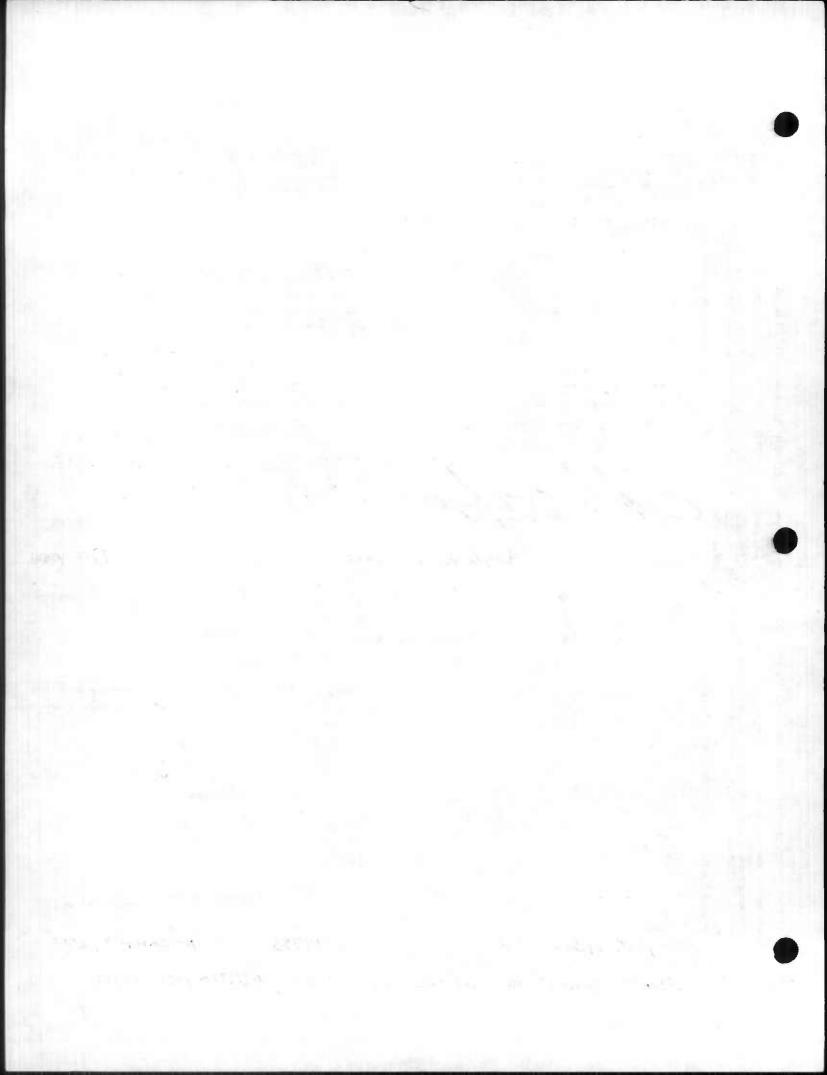
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iner	4e Facility Name ((If not institution, give	a street and nu	m <i>ber)</i>			4b. City, Town, or	Location of Dea	ith 4c.	County o	f Death			
	VA MARYI	LAND HEAL!	CHCARE :	SYSTEM			PERRY P	TNIC		CECI	IL			
	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 15. Under 1 Year 16. Under 24 Hrs. 16. Sex 16. Months Days Hours Min. 17. Age (In yrs. lest birthday) 18. Date of Birth (Month, Dey, Year) 18. Date of Birth (Month, Dey, Year)									Countr	ce (State d y) Ivania			
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to	DE	NewCast1e	2	F	irkwood							Yes Yes	2 🗆	
Directo	10e. Street and Nu	umber				10f. Zip Code			10g. Cit	izen of WI	nat Countr	y?		
Funeral	11. Marital Status			edent Ever in U,S	. 13. W	as Decedent of	Hispanic Origin? (uban, Maxican, Pua	Specify Yas or N	10-		- Amarica			
þ	1 Never Man	rriad 2 Marriad 4 Divorced	Armed For 1 XYas If Yes, Gir Yaar or D	2 No		Yes, specify Cl ☐ Yas 2 2 N		no Mican, etc.)			, White, et black			
Completed	/Sne	15. Decedent's Ed			16a. Decede	ent's Usual Occ	upation	orkina	16b. K	ind of Bus	iness/Indu	stry		
pe	Elementery/Sec		College (1-4or 5+)	lite. D	O NOT use reti	ne during most of wi red)	Ji Kiling						
Ö	12		n/a		ma	chinist			Fit	ers O	ampany	,		
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0	Robert I	Lee Jackson					Laura	Washingt	on Jac	kson				
	19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State								itate, Zip C	Code)				
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		5 Other (Specification)		Dela	-	terans M		11–14–00	Bear	, DE				
	21. Signature of Fundal Services Ligarpee 22. Name and Address of Facility The House of Wright Montuary													
	1/4	P.O. Box 447 Wilm., DE 19899												
1	23a. Part1. Enter the disease or complications that educed he death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or hear failure. List only one cause or each line. Approximately a such as cardiac or respiratory arrast, interval Enterval E										Approximat	0		
il r	Immediate Cause (Final disease or condition resulting in deeth) ALZHEIMER'S DEMENTIA Due to (or as a consequence of):													
Examiner	b. PNEUMONIA													
хаг	Sequentially list or if any, leading to it	onditions, mmediate		Due to (or	as a consequ	ence of):					i			
a	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury c.													
edicai	thet initiated event resulting in death)	15		Due to (or a	as a consequ	ence of):								
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lan											- 1			
Physician/	Part II. Other algni	Iffcant conditions	ontributing to de	eath but not result	ting In the un	derlying cause	given In Part I.							
P.									3 Prob	ably 4 🖄	Unkr			
by														
Completed								24a. Was en autopsy performed? 24b. Were autopsy available prior completion of					to	
pie											of d	eath?	HUSB.	
E								10	Yes 2	₽ No	10	Yes 2	No	
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0	examiner?		Hospital:	Inpatient 2 E	R/Outpatlent	2 DOA	Wher:	Home 5□Re		e DOtho	(Specific			
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Certification:	12 Natural 2 ☐ Accident	5 Pending investigation		of Injury th, Day Year)	Injury	28c. In W	lork? ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
2	3 Suicide	6 Could not be determined	208. Flace	Be. Place of Injury - At home, farm, street, factory, office				28f. Location (Street and Number or Rural Route Number					n <i>ber</i> ,	
5	4 Homicide determined building, etc. (Specify)							City or Town, State)						
edical C	29a. Certifier (Check only one)		niner: On the b				tima, deta and place y opinion, death occ						s)	
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		'				D393	170		Nov	ember	9 2	000		
	30. Name and add	ress of person who	completed caus	se of death (Item :	23a) (Type, P	rint)								
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ate	31. Date filed (Mor	nth, Day, Year)		Registrar's Signatu										
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State of Maryland / Department of Health and Mental Hygiene

		V-III	Cei	rtificate of	Death	Re	eg. No.	1 3	116	C		
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128	10e. Street and Number					10	0g. Citizen of \	What Cour	ntry?			
- E	4595 Pulaski Hio	hwav		21903			United	Stat	es			
"natural", or items 23a or 28a-f show edical Examiner must be notilled at leted by Funeral Director	11. Marital Status	12. Was Decedent Evar in	U,S. 13. 1				14. Rac	e - Americ	an Indian,			
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by by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Datas:		1∐ Yas 2⊠ No	Specify:		Specify	Whi	ite			
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nd Mental marked o urmatic ave To Be	William A Kelly				Lillian	T. Saun	dere					
Department of Heelih and Mental Hygiene importants if Itam 27 la marked other than "nany Injury or other traumatic avent, the Manner ance To Be Compi					Stata 7in	Code)						
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0 5 5 5	103 W. Stockton Street, Elkton, Maryland 21921											
g physician and as the bunal-transit	Dua to (or as a consequence of):											
g physician and as the bunal-transit	if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated evants											
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within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	3 Suicide 6 □ Could not b	28a. Place of Injury - At	281. Location (Street and Number or Rural Routa Number City or Town, Stata)									
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To the comp	29b. Signature and titla of certifiar									130		
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State Registrar	MOVE O O	2000	w 4	los	Mel							
3.2.10	NUV U 3	LUUU Jan	\sim	· Japon	A CALL							



State of Maryland / Department of Health and Mental Hygiene []

Certificate of Death 2. Deta of Death 1. Decedent's Nama (First, Middla, Last) 3 Time of Death **Physician** November 2000 Amelia Elizabeth Johnson 0500 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent & Queen Anne's Hospital Chestertown Kent 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 27, 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** 1□ M 2XF 219-42-8851 Stevensville, MD Director Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No r 28a-t Directo Maryland Caroline Marydel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23s or the Medical Examiner must be 1 27115 Temple Road 21649 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea.
Department of Health and Mental Hyglene.
Important: If then 27 is marked other the.
any Injury or other trauments. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ဩ No If Yas, Giva Yaer or Dates: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify. Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own home 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) William Weldon Jones Mary Amelia Grimes 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) Karen Marie Cantwell 23751 Bridgetown Road, Henderson, MD 21640 20a. Method of Disposition

1 Burial 2 Cramation 3 Ramoval from State 20b. Place of Disposition (Nama of cematary, crametory or other place) Data 20c. Location - City or Town, Stata Sudlersville Cemetery 11/11/2000 Sudlersville, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 at causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest Approximata Intarval Batween Onsat and Death Physician /Medical Immediete Causa (Final diseasa or condition rasulting in death) 30 NOT Cancer Examiner Dua to (or as a consaguance of) Physician/Medical Examiner The law requires that the death certificata be executed Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury Dua to (or as a consequence of) Box 68760, that initiated events rasulting in death) Last Dua to (or as a consequence of) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown ata hes been signed page 2 should be de Be Completed by Division of Vital Records, 24b. Were eutopsy tindings 24a. Was an autopsy availabla prior to complation of cause of death? 1 🗆 Yes 2 (2)No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: 25. Was case reterred to medical axaminar? 26. Placa of Death (Chack only one) Hospitel: Other: 4 Nursing Homa 5 Residence 8 Othar (Specify) Medical Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 35400A After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred Injury st Work? 5 Panding invastigation Netural 1 ☐ Yas 2 ☐ No death. 2 Accidant after death 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 | Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Data signed (Month, Day, Year) 29b. Signatura, and utility of o 29c. Licansa number 7/2000 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Didoralo Dive Charle, mo 21619 2108 MD 10 31. Data filed (Month, Day, 32. Registrar's Signatura State NOV 08 2000 Registrar

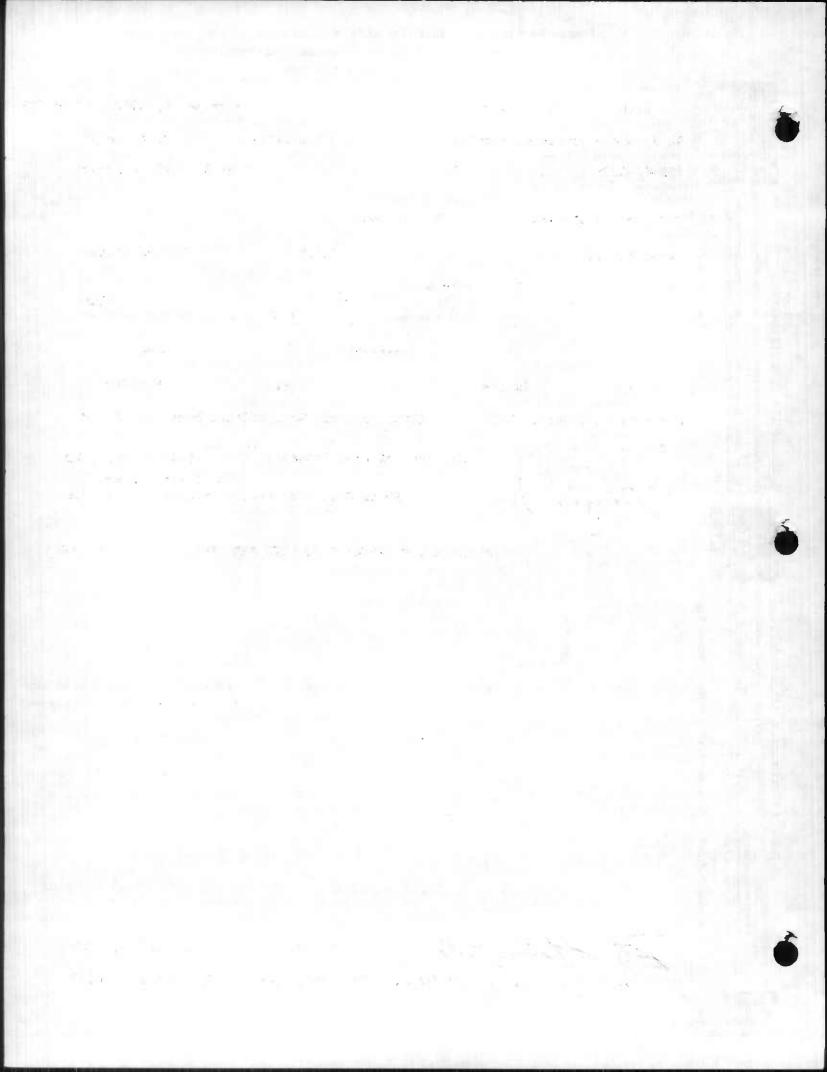
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State of Maryland / Department of Health and Mental Hygiene

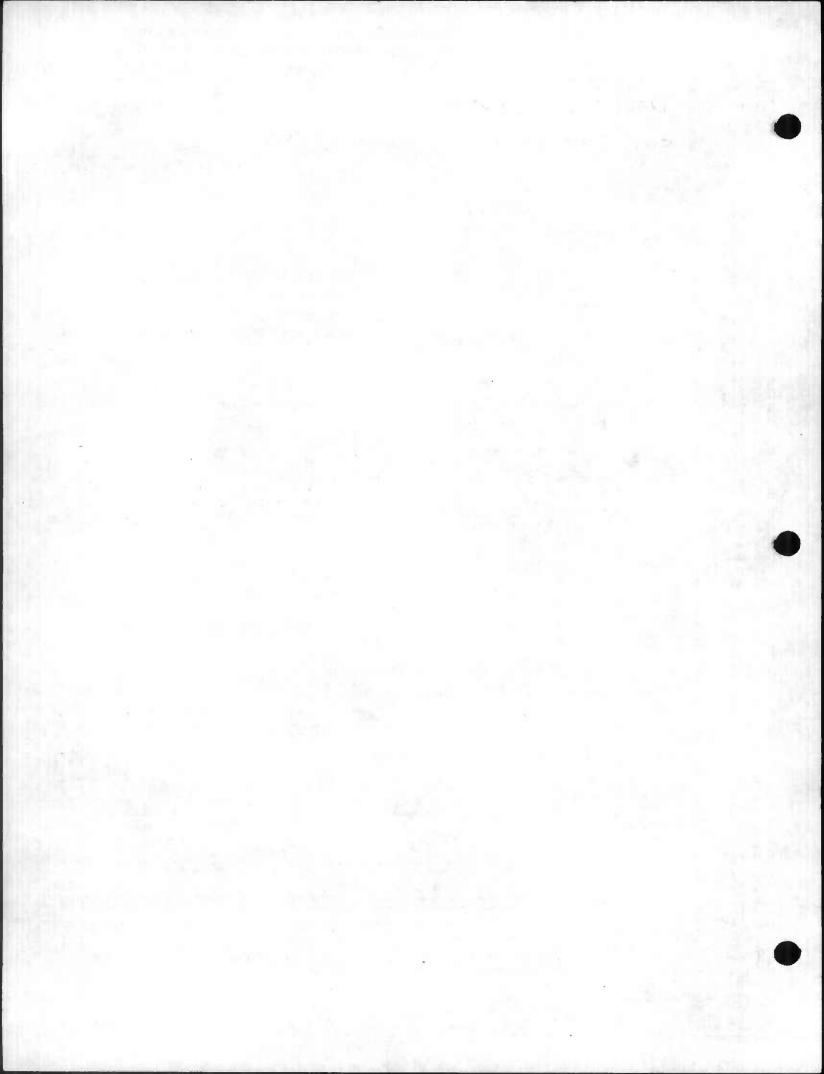
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ei Status	12. Wes Decedent Ev Armed Forces?	er in U,S.	13. Wes Dec	cedent of His	spenic Origin?	(Specify Yes or No erto Rican, etc.)	o- 14. Rai	ce - Americ	
lever Merried 2 Married Wildowed 4 □ Divorced	1 X Yes 2 □ No If Yes, Give Yeer or Dates:	1964- 1968	-	2 No			Specif	v.	hite
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e end eddress of person who	completed cause of dee	eth (item 23e)	(Type, Print)						
ID G. SROUR, I	1.D., 9901	MEDICA	L CENTE	ER DRI	VE, RO	OCKVILLE,	MARYLA	ND 2	0850
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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yes **Physician** DAVID G. JOHNSON 0905 NOV 2000 07 /Medical 4a Facility Name (If not institution, give street end number) 22 SOUTH 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore SHOCK TRAUMA GREENEST CENTER N/A If Under 24 Hrs. 8. Date of Birth Pay. Year 61 Feb. 9, 1961 If Under 1 Year 7. Age (In yrs. lest birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months XIM 20 F 39 Hours Pittsburg, Pa. 204-48-0805 Director Usual Residenca of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at 1 Yes 2 No Md Prince George's Lanham Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? deeth with 7001 Nightingale Court 20706 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 N Married Specify: White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filigd within 72.1 Department of Health and Mental Hyglena. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Wed call page. 15. Decedent's Education (Specity only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Computer Technician CSC Computer Sciend 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Edward Albert Johnson Wilma Jean Dunn 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Anneliese Mary Johnson/Wife 7001 Nightingale Court, Lanham, Md 20706 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Dale Cemetery 11/14/00 Pittsburg, Pa. 22. Name and Address of Facility
PHILIP D.RINALDI FUNERAL SERVICE 11818 New Hampshire Avenue Silver Spring 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Maryland Approximate shock, or heerf teilure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Sepsis **Examiner** Due to (or as a consequence of) Examiner TISSUR In fection the death certificate be executed physician and is the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequenca ot) Box 68760. Physician/Medical Due to (or as a consequence of) 65 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 3 ESRD Division of Vital Records. P 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate has page 1 ☐ Yes 2 ☐ No 1 Yas Hospital or Attending Physician: 25. Was case reterred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this 27. Manner of Death 28a. Date of injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending after death. Director: Aft 1 Yes 2 No investigation 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) edical 29a. Certifier and manner stated. 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Contical Care 11-07-00 30. Name and address of person who completed cause of death (item/23a) (Type, Print) 22 South Breene laureen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Deneva NOV 09 oaks Registrar



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #5,11/9/2000, BMW, Montg. Co. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** Parker George Johnson II November 2, 2000 3:50pm /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 18026 Red Rocks Dr. Germantown Montgomery 8. Dete of Birth (Month, Day, Year)
Dec. 14, 1965 If Under 24 Hrs. 5. Sociel Security Number 2200-60-2831 If Under 1 Year 9. Birthplace (Stata or Foraign Country) New York 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1♥ M 2□ F Yrs. 34 Director Usual Residence of Decedent with the Maryland 10a. Stete 10b. Counts 10c. City, Town or Location item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director Md. 1 ☐ Yas 2 ☑ No Germantown Montgomery 10e. Street and Number 10f. Zio Code 10g. Citizen of Whet Country? 18026 Red Rocks Dr. 20874 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bleck, White, etc. efter ∏Yes 2 1 No 1 Yas. Give 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 72 hours 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondery (0-12) College (1-4or 5+) 5+ permit. Peges 1 and 2 should be filled with Department of Heelth and Mental Hygien Important; if Item 27 is married other twa any Injury or other traumatic averation. Dir. of Competitive Assets Marriott Corp. 17. Father's Name (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maidan Sumame) Be George P. Johnson Ellen Quitne 19e. Informent's Neme/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra L. Johnson (Wife) 18026 Red Rocks Drive - Germantown, Maryland 20874 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State Mt. Zion Cemetery 11/7/00 4 ☐ Donetion 5 ☐ Othar (Specify) York, PA 22. Name end Address of Fecility DeVol Funeral Home 21. Signeture of Funeral Service Licensel 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death **Physician** /Medical Immediate Causa (Final Head and Neck Cancer diseese or condition rasulting in deeth) 23 Months Examiner Due to (or as e consequance of) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last attending physician end for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? peen page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 25t No certificata Division of Vital al or Attending Physician: T s after deeth. I Director: After this certificat ed in by the funeral director, p Be 25. Wes case reterred to medical examinar? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 NRasidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury осситеd 28b. Time of 28c. tnjury at Work? Injury 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled is hin 24 hours at the Funeral DI npletely filled in 29e. Certifier 1 🖸 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et tha time, data end plece, end dua to the cause(s) and menner steted. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 12 D 32407 November 3, 2000 30. Name and address of person who complated cause of death (Item/23a) (Type, Print) Suite #300 Joseph A. Haggerty M.D. 9707 Medical Center Dr. Rockville, Md. 20850 31. Date filed (Month, Day, Year) Registrer's Signeture

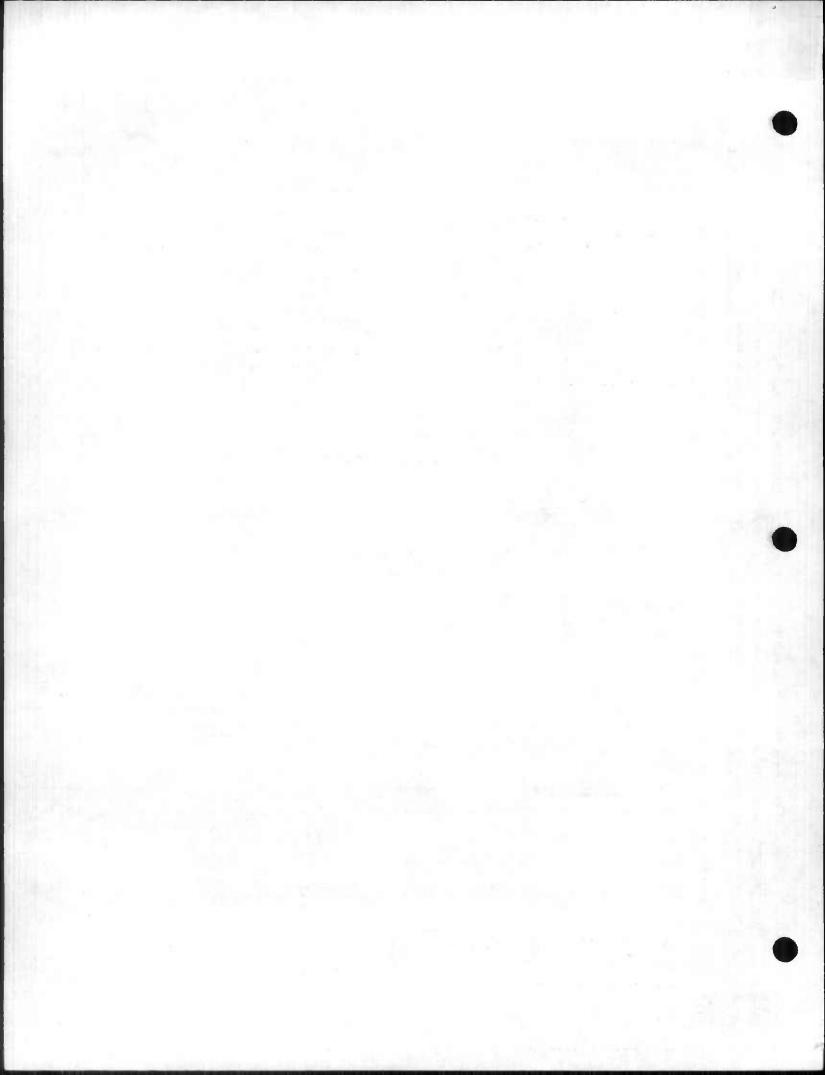
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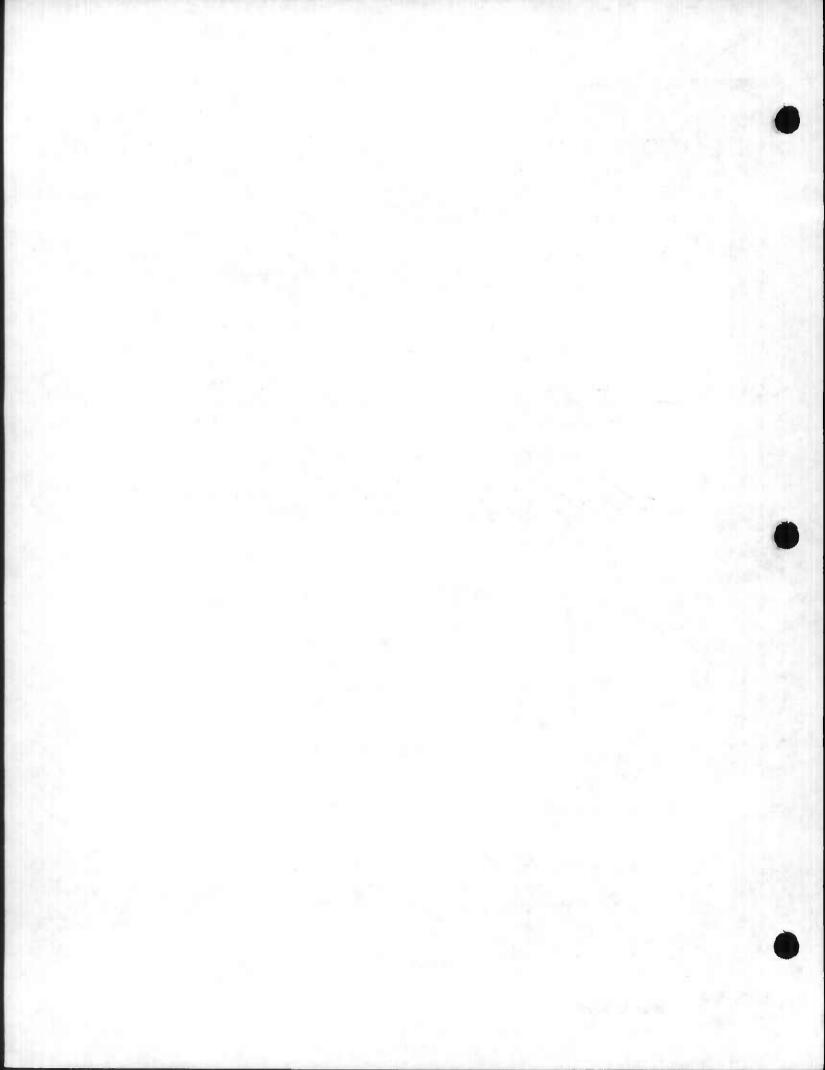
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State of Maryland / Department of Health and Mental Hygiene

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a a	permit. Pe Departman Important: eny Injury	21. Signature of Pubers Services de	6	/	Hicks	Home		erals, P.			
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	State	31. Dete filed (Month, Day, Year)	32. Regi	strer's Signeture	1	1					

Registrar



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			tificate of	Death	R	eg. No.	
Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Y	3. Time of Dea
/Media	cal	Leroy Oliver King		45 Ois Tour 1		er 2, 200	
Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	cation of Death	4c. County of	
		Peninsula Regional Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	Salisbury If Under 24 Hrs.	8. Date of Birth	Wico	
Funeral Director		213-24-0236 1 [™] 2□ F 70 Yrs.	Months Days	Hours Min.	(Month, Day, Jan. 2,	Year)	D. Birthplace (State or For Country)
		Usual Residence of Decedent			Jalle Z,	1730	Virginia
filed within 72 hours after death with the Manyland Hygiene. ther then 'natural', or items 23a or 28a-f ehow ent, the Medical Examines must be notified at		10a. State 10b. County 10c, City, Town or Local	ation				10d. Inside City Li
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1 2 × 2 × 2 × 2 × 2 × 2 × 2 × 2 × 2 × 2	Director	10e. Street and Number	10f. Zip Code		1	0g. Citizen of Wh	at Country?
permit. Fages i end z should be liled within 72 hours aner death with the Marylan Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Indeportant: If them 27 is marked other than "natural", or frems 23a or 28a-f show any Injury or other treumatic event, the Medical Existence must be notified at once.	Ta .	441 West Market Street	218			USA	
them a	Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. W	as Decedent of H Yes, specify Cube	lispenic Origin? (Spe en, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
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other of	Be C	17. Fether's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, N	/aiden Sumame)	
Mentel Mentel arked o	TOE	Leroy Daniel King		Mary Si	mith		
and Men le marke		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street	and Number or Rura	al Route Number	City or Town, St.	ate, Zip Code)
alith n 27 i		Mary B. King/wife 441 W	. Market	Street - S	now Hill	l, Maryla	nd 21863
of He		20a. Method of Disposition 20b. Place of Disposition cemetery, creme	ition (Name of atory or other place	>e)	Dete	20c. Location - Ci	ty or Town, State
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Departr Importu any Inji		21. Signature of Funeral Service Licensee 22.	Name and Addres				- Salisbury, N
20529		Antrice / Allow	Iolley Me	morial Ch	anel		
		23a. Part 1. Enter the disease, or complications that cause the death. Do not enter shock, or heart failure. List only one cause on each rise.				est,	Approximate
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/Medical		Immediate Cause (Final disease or condition a. Heart failure					241
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0 0	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Oth	or.		nce 6 Other	(Specify)
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after death. Director: After	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, offica	4	28f. Location (St. City or Town		or Rural Route Number,
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		29b. Signet up and the certifier	29c. License		25		Month, Day, Year)
J MP		mo ome		54127		11/03/00	
IVA		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr					
1		Alon Davis #3 Bistate Blvd Delmar, 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	Maryland	21875			
Sta Registr		31. Date filed (Month, Day, Year) NOV 0 6 2000 32. Begistrar's Signature	Low	,			

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State of Maryland / Department of Health and Mental Hygiene 0 0 37132

			Certificate of	Death	Reg. No.	01102
Dhuaisia	Decedent's Neme (First, Middle, Last)		- 1 C-SE - 1 = 1	2. Dete o		3. Time of Death
Physician /Medica	RUSA MAE	KEYS		Novem	ber 9, 200	00 9:30 PM
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Funeral Director		7. AGB (III yis. Iasi i	Yrs. Months Deys	Hours Min. (Month	of Birth h, Dey, Year) r 21,1926	Birthplace (State or Foreign Country) Virginia
how	10a. State 10b. County	10c. City, To	own or Location		MILLE THE	10d. Inside City Limits
death with the Meryland ms 23a or 28a-f show Linual be notified at	MD Charle	s (Cobb Island			1 XYes 2 No
or 2	10e. Street and Number		10f. Zip Code		10g. Citizen of Wha	t Country?
ath v	14901 Potomac Ri		2062		USA	American Indien,
020 urs after al', or the	3 X Widowed 4 □ Divorced	. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:	13. Was Decedent of H If Yes, specify Cube	lispanic Origin? (Specify Yea o en, Mexican, Puerto Rican, etc. Specify:		White etc. White
22 ho	15. Decedent's Educa (Specify only highest grade		Se. Decedent's Usuei Occup (Give kind of work done	etion during most of working	16b. Kind of Busine	ess/Industry
2121 d within piene. r than "r	15. Decedent's Educe (Specify only highest grade of Elementary/Secondery (0-12)	Coilege (1-4or 5+)	life. DO NOT use retired	d)		
nd 21 e filed w el Hygier other th	12	1	Vice Presi		Banki	ng
Maryland d 2 should be file ith and Mentel Hy T'ls marked oth Traumatic event	James Perrin			18. Mother's Name (First, Mil		Domesica
arylan should be nd Mentel marked o	19e. Informent's Neme/Reletionship (Type	Duint	Oh Maliina Address (Street	Sally Virgi	0	
Baltimore, Maryland 'permit. Pages 1 and 2 should be filed Department of Heelth and Mentel Hyg Important: if item 27 is marked other eny injury or other traumatic event, once.	Debbie Canterbur 20e. Method of Disposition W Burial 2 Cremetion 3 Re- 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	novel from State Nati	onal Memor	ial Park11/1 -ECHOLS FUNI	13/00 Fall ERAL HOME,	S Church, VA
	23a. Pert1. Enter the disease, or complice shock, or heart feilure. List only one	tions that saved the death. D		X 567 LA PLA) 6 4 6 Approximete
Box 68760, each certificate be executed when the same certificate be executed attending physician and life use as the burial-transit		Dubel Due to (or es Panaeul	e consequence of): Lamber e consequence of): a consequence of):)		
P.O. BOX hat the death ce d by the attendii	Part If. Other eignificant conditions contr	buting to death but not resulting	g in the underlying cause giv	ren in Pert I. 23b.	Did tobacco use contri	bute to the cause of death?
p. P.O. that the detached detached					1 ☐ Yee 2 ☐ No 3	☐ Probably 4 ☐ Unknown
cords, requires the been signe should be of the standard be of the sta		AL E	N/S		Wes an eutopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of deeth?
The lay				OF SHAPE OF	1 Yes 2 No	1 Yes 2 No
Vital I				26. Plece of Deeth (Check of	only one)	
Of Vital Physician: T			Outpatient 3 DOA Oth	ner: Nursing Home 5	Residence 6 Other ((Specify)
After fune		(Month, Day Year)		Yes 2 No	cribe how injury occurred	os Comi Conto Number
DIVI	4 Homicide determined	28e. Plece of Injury - At home, building, etc. (Specify)		City o	ion (Street and Number of Town, State)	
Division To the Hospital or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the		tan: To the best of my knowled r: On the basis of examination and menner steted.	end/or investigation, in my o	ppinion, death occurred at the t	time, dete end plece, and	due to the cause(s)
To the With To the Com	· mite a J	art	Do	02/03/	29d. Date signed (A	
	30. Name and address of person who com Michael Leather	wood, M.D. 12	070 Old Li	ne Centre,Wa	aldorf,MD.	20602
State Registra	4 4 0000	32. Registrer's Signeture	B. Sports			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death Day Physician Month Dolores M. King 3, 2000 3:40 AM November /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince Georges Laurel If Undar 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) June 4, 1937 9. Birthplaca (Stata or Foreign Country) New York 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1 M 2 TF 63 133-28-5829 Yrs Director Usual Rasidance of Decedeni the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 N Yas 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zio Code 10c. Citizen of What Country? 20906 United States Items 23a 2346 Cold Meadow Way permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natural", or Items 23, may Injury or other fraumatic event, the Medical Examiner main Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 1 ☐ Nevar Married 2 N Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Sales Rep. BC/BS Health Insurance 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be James Stewart Hattie Johnson 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) John W. King, Sr. - Husband 2346 Cold Meadow Way, Silver Spring, MD 20906 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 11/8/00 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat@ra of Funeral Sarvice Licensee 22. Nama and Address of Facility
McGuire Funeral Service, Inc. pour 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final Cardiopulmonary Arrest minutes disaasa or conditio resulting in death) Examiner Dua to (or as a consequence of): Physician/Medical Examiner Cardiac Arrhythmia hour that the death certificate be executed sician and buriel-trans Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): physician s the burie P.O. Box 68760. Anoxic Encephalopathy minutes Dua to (or as a consequence of): USB 88 atten signed by the aid be detached for Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yaa 2 No 3 Probably 4 Unknown Status Post-Craniotomy Atrophy Records, P The law requires 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Right sided weakness page 2 certificate 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: director Be 25. Was casa refarred to medical 26. Piaca of Death (Check only ona) Hospital: 1 ☑Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 8 Othar (Specify) Certification: To this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? After 12 Waturel 5 Pending Invastigation s after deem. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicida 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated. Medical (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and mannar atated. within 2 ş 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and litla of certifier 0 7.2 11-3-2000 D 24174

DHMH 16 Rav 6/95

State

Registrar

outs!

7350 Van Dusen Road Suite 380, Laurel, MD 20707

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

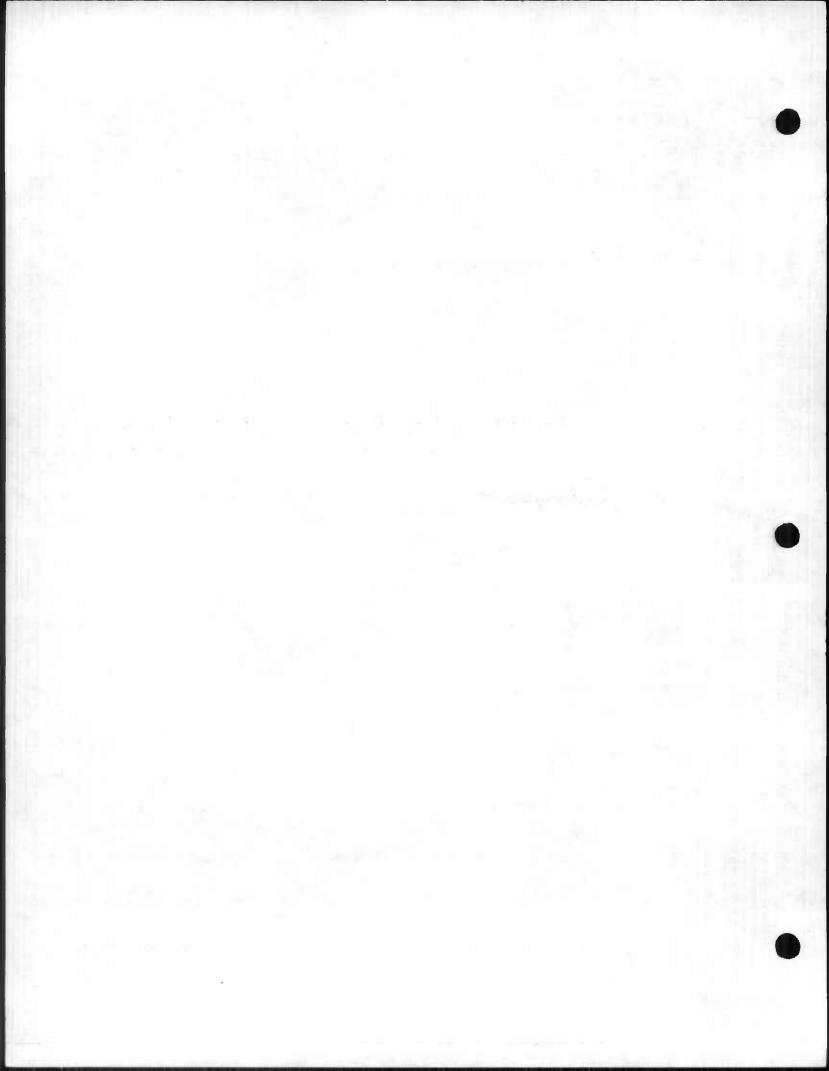
2000

32. Registrar's Signatura

Padmaja S. Udapi, M.D.

NOV 08

31. Data filed (Month, Day, Year)

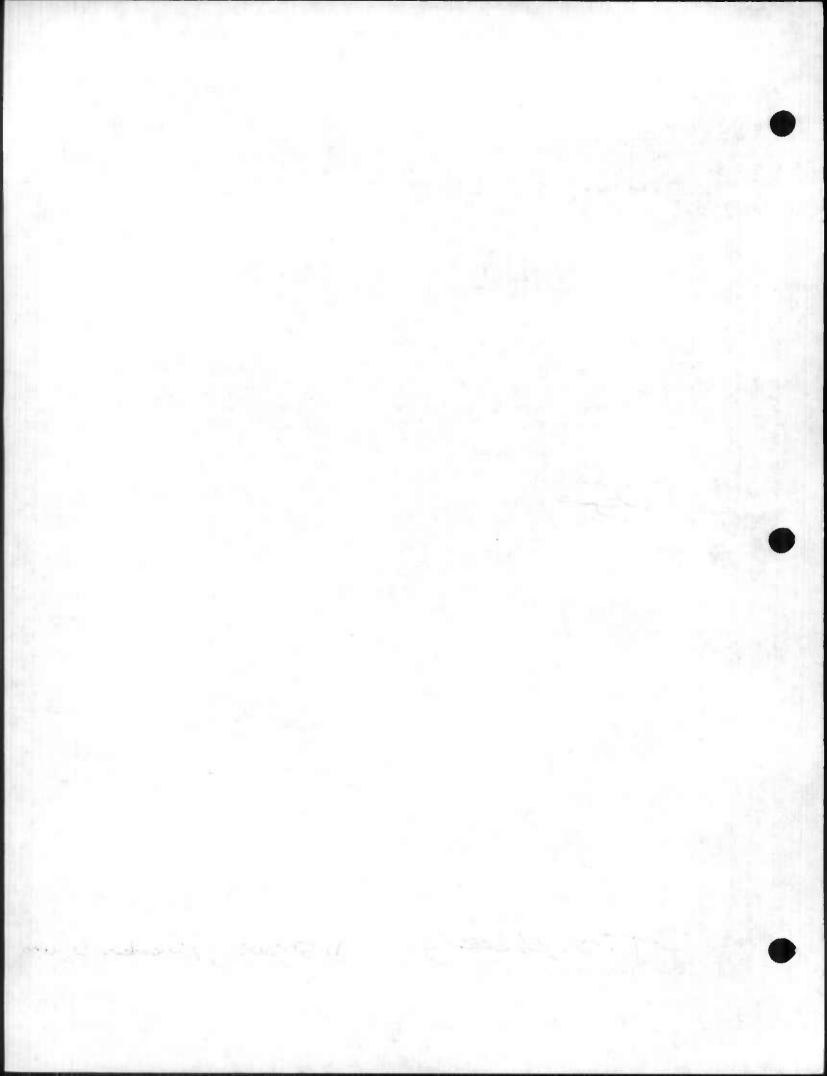


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State of Maryland / Department of Health and Mental Hygiene

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Reg. No.					

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Medical		TECH S. KR	The second second							7. 3, 2		4:3
aminer		e (If not institution, gi)				4b. City, Town,			County of De	
		ARE FERNWO				If Under	1 7000	BETHES			ONTGO	
eral ctor	5. Social Securi	6145	Sex 7. A	ge (In yrs. las	Yrs.	Months	Days		in. (Month,	Birth Day, Year) 4/14		irthplace (State Country) ECHOSLOV
w	Usual Residence 10a. State	10b. County		10c. City,	Town or Loc	cation						10d. inside C
Director	NONE	NONE		WASI	HINGTO	ON, D	С			76.		1 XYes
Director	10e. Street and	Number				10f. Zip				10g. Citize	en of What C	Country?
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by Funeral		Merried 2 Married ad 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	7	If	was Deced f Yes, sped 1 ☐ Yes	cify Cub	tispantc Ortgin? an, Mexican, Pu Specity:	erto Rican, etc.		Black, Wh	
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70		s Name/Reletionship	(Type, Print)		19b. Maitin	ng Addrass	(Street	and Number or		•	Town, Stata,	Zip Coda)
To Be Comp	PETER K	RHNAC / FR	IEND	- 1	1730	RHOD	E IS	SLAND AV	E. STE	.#403.	NW. WA	20 ASHINGTO
9	20a. Method of	1.77		20b. Plac	e of Dispos				Date			r Town, State
ام الم		2 Cremation 3 on 5 ☐ Other (Special			CONAL				11/7/0	O FAL	LS CHU	JRCH, VA
eny injury o pose.	21. Signature o	Funeral Service Lice	DANIEL S	MONS	DA	ANZAN	SKY-	ss of Facility -GOLDBER	RG MEMOR	CIAL CH	APELS,	, INC.
	23a. Part1. Enf	ter the disease, or cor heart failure. List only	nolications that cause	d tha daath.							,	Approxima Intervat Be
an cal	Immediate Cau	se (Final										Onset and
ner	disease or con- resulting in dea		a. ARRHYTI	Due to (or a	e e consen	mence off.						MINUTE
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~ 5			d									
<u>a</u>												
- 0									1	Did a characteristic		
hysic	Part II. Other si	gnificant conditions	contributing to death i	out not resulti	ing in the ur	nderlying o	ause gi	en in Part I.				te to the cause
e detached for use by Physician/I	Part II. Other si	gnificant conditions	contributing to death t	out not resulti	ing in the ur	nderlying o	ause gi	ven in Part I.				te to the cause
by be	Part II. Other si	gnificant conditions	contributing to death t	out not resulti	ing in the un	nderlying o	ause gi	ven in Part I.	24a. V		No 3□:	Probably 4 2 b. Were autopsy available prior completion of
2	Part II. Other si	gnificant conditions	contributing to death	out not resulti	ing in the ur	nderlying o	ause gi	ven in Part I.	24a. V	Yes 2 2 Ves en autops erformed?	No 3 1	Probably 4 2 b. Were autopsy svaitable prior completion of of death?
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be of Little in plack indelible lik. Assule	All Cobies Wie re	gible.	0 22 4 0	20
State of Maryland / Department of Health and	Mental Hygiene] []	3713	5
Certificate of Death	Reg. No.			
	2. Dete of Deeth Month Dev	Year	3. Time of Do	eati

Physician /Medical **Examiner**

MARY M. KUSHNER

1. Decedent's Neme (First, Middle, Last)

Dey 2000 NOV. 3, 5:50PM

10d. Inside City Limits

WHITE

5 day

dan.

5493

1 Yes 2 No

/Medical Examiner P.O. Box 68760.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To

4b. City, Town, or Location of Deeth 4a Facility Neme (If not Institution, give street end number) 4c. County of Deeth SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE A

SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE

A Security Number 6. Sex 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) MONTGOMERY Birthplace (State or Foreign Country) 1□ M 2 F **Funeral** Months Deys Hours Min. 069284778 95 JUNE 23,1905 RUSSIA Director Usuel Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at Directo MONTGOMERY MONTGOMERY VILLAGE 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? or items 23s or permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mentel Hygiene.

Important: If If them 27 is marked other than "natural", or hammers highly or other traumatic event. 20506 BEAVER RIDGE RD. 20886 USA Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Sfetus 1 Yes 2XXNo If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify ρ Specify. 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 OWNER RETAIL 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ABRAHAM MALKIN BERTHA CHERNIAK 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) LAWRENCE KUSHNER / SON 20506 BEAVER RIDGE RD., MONTGOMERY VILLAGE, MD 20886 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Remove from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) NATIONAL FH CREMATORY 11/7 FALLS CHURCH, VA 21. Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 DANIEL SIMONS 23a. Pert1. Enter the diverse, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting In death) Examiner ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lasf VErwonid Physician/Medical Due to (or es e consequenca of): Ecmia Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Were autopsy findings evailable prior fo completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 2 No

1 Tyes 2 KNo 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 StInpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deetl 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner stated. 29a. Certifier

29b. Signeture and fitte of certifier (2dV)

29c. License number D41162

Drive

29d. Date signed (Month, Day, Year) Novemberroy 2000

Germanteun MP 20874

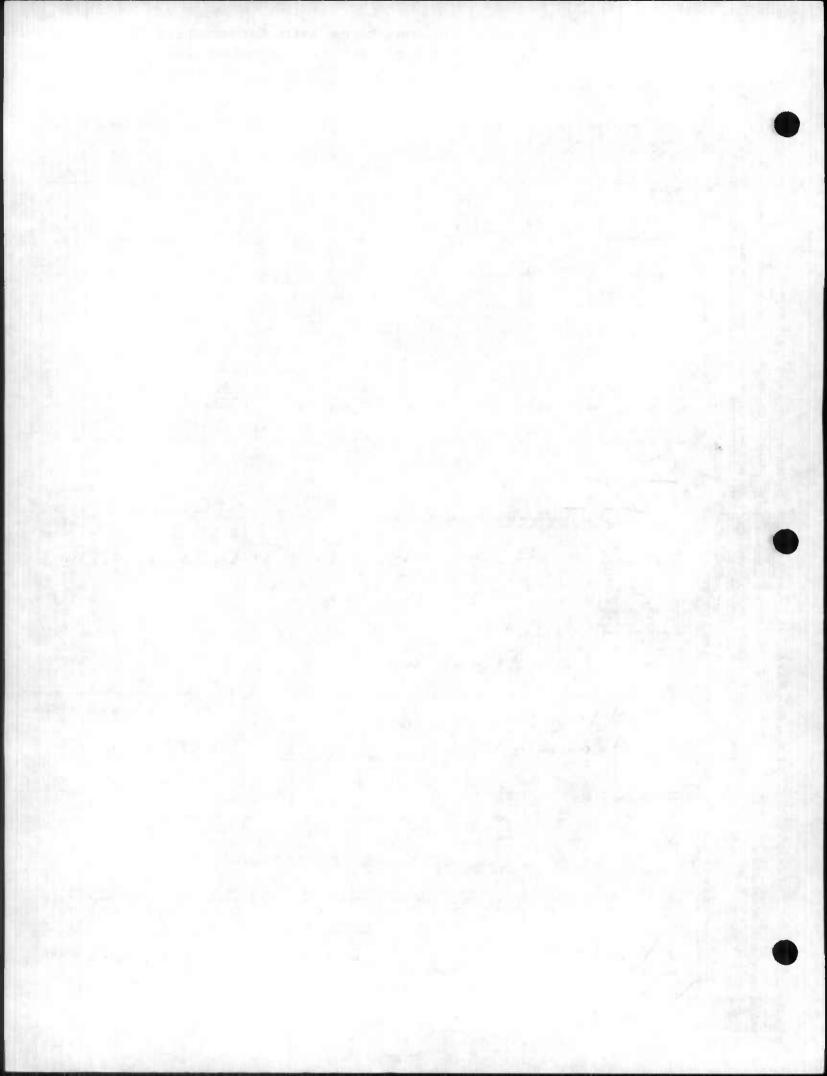
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9529 Doctors

Ganti

31. Date filed (Month, Dey, Year) NOV GG 2000 32. Begistrer's Signeture

Registrar **DHMH 16 Rav 6/95**

State



			Plea	se i				/ Depa		t of H	lealth an			giene	Die.	37136
	Physicia /Medica	n al		ame	s Nat	hanie	1 I	Lawson					2. Data of De Month Novemb	Day er 4, 2	Yaar 000	3. Time of Death
	Examine	er	4a Facility Name (If not institution Harford Mem								Havre	de	Grace		y of Death Harfo	
)	Funeral Director		5. Social Security Number 213-18-6512	6. Sex	Sex 7. Age (In yrs. last birthday) 81 Yrs.					1 Year Days	If Under 24 Hours	Hrs. Min.	8. Data of Birth (Month, Day, Year) July 6, 1919			place (State or Foreign ntry) W Jersey
); date	e Maryland Be-f show diffed at		Usual Residence of Decedent 10a. State 10b. County Maryland C	eci	1	100	c. City,	Town or Lo	cation	Col	ora					10d. Inside City Limits 1 ☐ Yes 2 K No
3		al Directo	11. Marital Status 12. Was Decedent Evar in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-										Whet Country?			
050 A		by Funeral										eck, White,	can Indian, etc. White			
28SO 21215-0020	iwithin 72 ho iene. Than "natur the Medical.	Completed	15. Deceden (Specify only higha: Elementary/Secondary (0-12)	sf grade							ation during most of				edica	dustry 1 Center , Maryland
The second second	E T O O O	o Be C	17. Father's Name (First, Middle, Jame	Last)	awson						18. Mother's	Name	(First, Middle	, Maidan Suma tone	ma)	
00 (Maryland	nd 2 shoul sith and M 27 le mart r traumatt		19a. Informant's Name/Relations Mary E. Lawson											per, City or Town		
11/04/ Baltimore, N	Pages 1 an ent of Heal nt: If Nem 2 ry or other	-	20a. Method of Disposition 1 □ Burlal 2 ② Cremation 4 □ Donation 5 □ Other (S	3 □R		State	cen	ce of Disponetery, crer	sition (Nan	ne of ther plac	ea)	1	Dete	20c. Location	- City or T	
Balti	Demit. Departr Importa any inju		21. Signature of Funeral Sarvice	.17) Itek	NOA.	S.	L P	ee A. erryv	Pat ille	, Mary	lar	d 2190	neral H 3-0766	ome,	P.A.
(V.N)	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List	compli only or	cations that ne cause on	caused the each line.	death.	Do not ani	er fha mod	la of dyin	g, such as ca	rdiac o	or raspiratory a	arrast,		Approximate interval Between Onset and Death
na nie	Examiner	Jer	disease or condition resulting in death)	a				is a consec		May 1	une	-17			1	Lyens
Natha 68760,	bur bur	8	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initileted events resulting in death) Last).	Chron	to (or a	is a conseq	D Ms							lyon
NOX BOX	ath certification or usa as	lan/M			I	Atri	al	Ribon	Matio	Y)					1	ZEyem
s, P.o.	v requires that the death certificate been signed by the attending phys should be detached for use as the	oy Physic	Part II. Other significant condition								en in Part I.	general	10	Yes 25 No		to the cause of death? obably 4 Unknown
Record	e law requira has been sig	Completed by Physician/Medic	,							-	-		perf	s an autopsy ormed?	Of Of	Vere autopsy findings vailable prior to ompletion of cause I death?
/ital	certificate rector, pag	20 20 20 20 20 20 20 20 20 20 20 20 20 2	25. Was casa ratarred to medical examiner?	-								Deat	1 Check only	Yas 2 1 No	1	Yes 2 No
200	Fish Fish	0	1 Yes 2 No 27. Manner of Death			Inpatient of Injury oth, Day Yea		NOutpatier 8b. Time of Injury		Oth PBc. Injur Wor	4 U Nurs			idenca 8 🗆 O how Injury occ		(6)
Lau	or Attending after death. Director: Afte I in by the fune	Medical Certification:	1 CNetural 5 Pendin investing 3 Suicida 6 Could determined	nol be		a of Injury - ding, etc. (S)			М	10	Yes 2□No		28f. Location City or To	(Street and Num own, State)	n <i>ber or R</i> ui	ral Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	dical C	29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Phys Examir	ner: On the !	e best of my basis of exa-	y knowle mination	edge, deeth	n occurred vestigetion	et the tin	ne, dete and p	olaca,	end due to the ed at the time	cause(s) end r , date and place	nenner as	stated. to the cause(s)
	within To the comple	Me	29b. Signature and title of certifie	Done	lno-	1.no)		290		e number			29d. Dete sign	HOO	, Day, Year)

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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

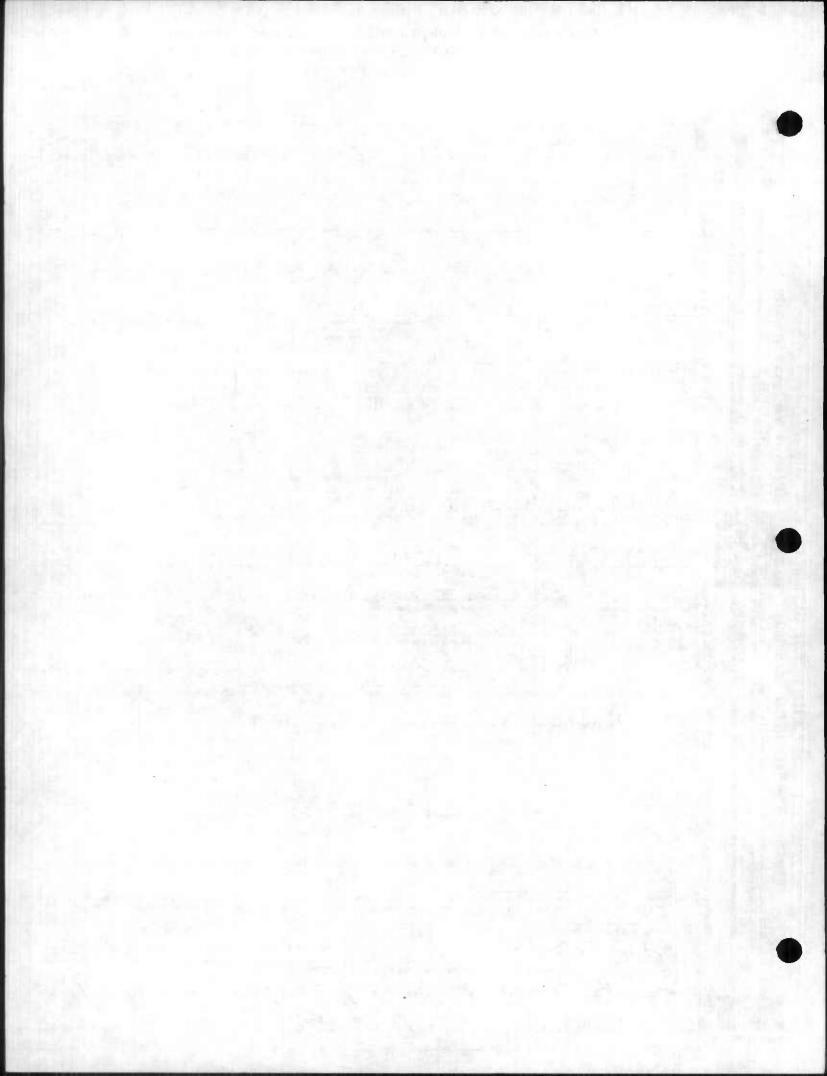
L. L. W. Duck (of Odforcal Way

31. Date tiled (Month, Day, Year)

NOV 0 8 2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Florence Victoria Lange November 2, 2000 11:15PM /Medical 4a Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Gaithersburg Montgomery Village Rehabilitation Montgomery ff Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex 8. Dete of Birth (Month, Day, Year) **Funeral** Min. Months Deys Hours I 1□ M 2X F Director 83 7, 1917 220-60-0608 North Dakota Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Nerve 23s or 25s-f show iner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14008 Parkvale Road Funeral 20853 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian. 11. Maritel Stetus Black, White, etc. the Medical Examiner 朝 1 Never Married 2 Married "natural", or 1 Yes 2 No Specify: Specify: py 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H ant: If them 27 is marked oth Be Peter Scott May L. King 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley W. Lange/Husband 14008 Parkvale Road, Rockville, Maryland 20853 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20a. Mathod of Disposition 20c. Location - City or Town, State important: If it, ny injury or Nov 9 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cemetery 2000 le Veterans Cemetery 2000 Crownsville, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signalule of Funeral Service Licensee Rockville, Inc. 300 West Montgomery Avenue اله M00803 Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medicai Pneumonia Examiner Due to (or as a consequence of): Examiner the death certificate be asscuted attending physician and for use as the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Physician/Medical thet initieted events resulting in death) Last Due to (or es a consequence of): USB BS I ed by the s Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 □ Probably 4 □ Unknown that signed t p 24b. Were autopsy findings available prior to completion of ceuse of death? should l 24a. Was an autopsy performed? Completed page 2 certificate has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4∑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) To 1 ☐ Yes 2 X No After this funeral 28a. Dete of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation 1 (Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours a the Funeral D npletely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

Division of Vital Records, The law Physician: i or Attending P Hospital To the H within 24 To the F

Baltimore,

Box 68760.

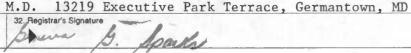
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31. Date filed (Month, Day, Year) NOV 08 2000

Anushiravan Dadgar,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

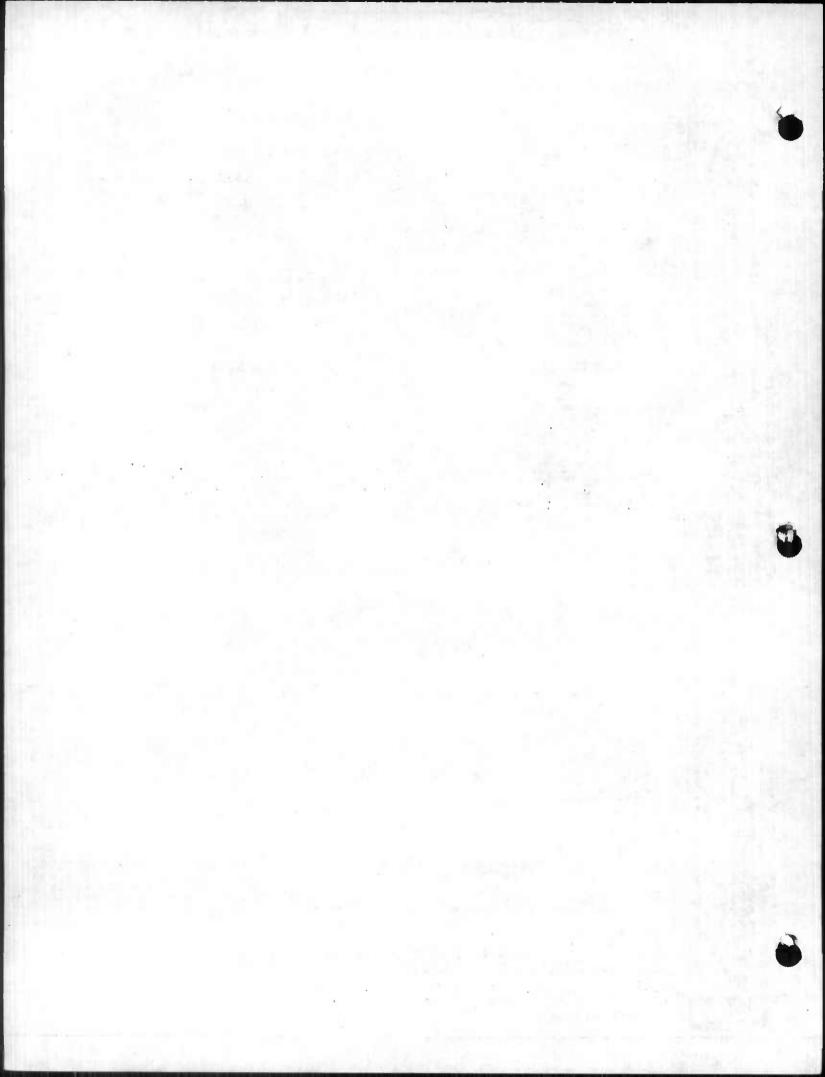


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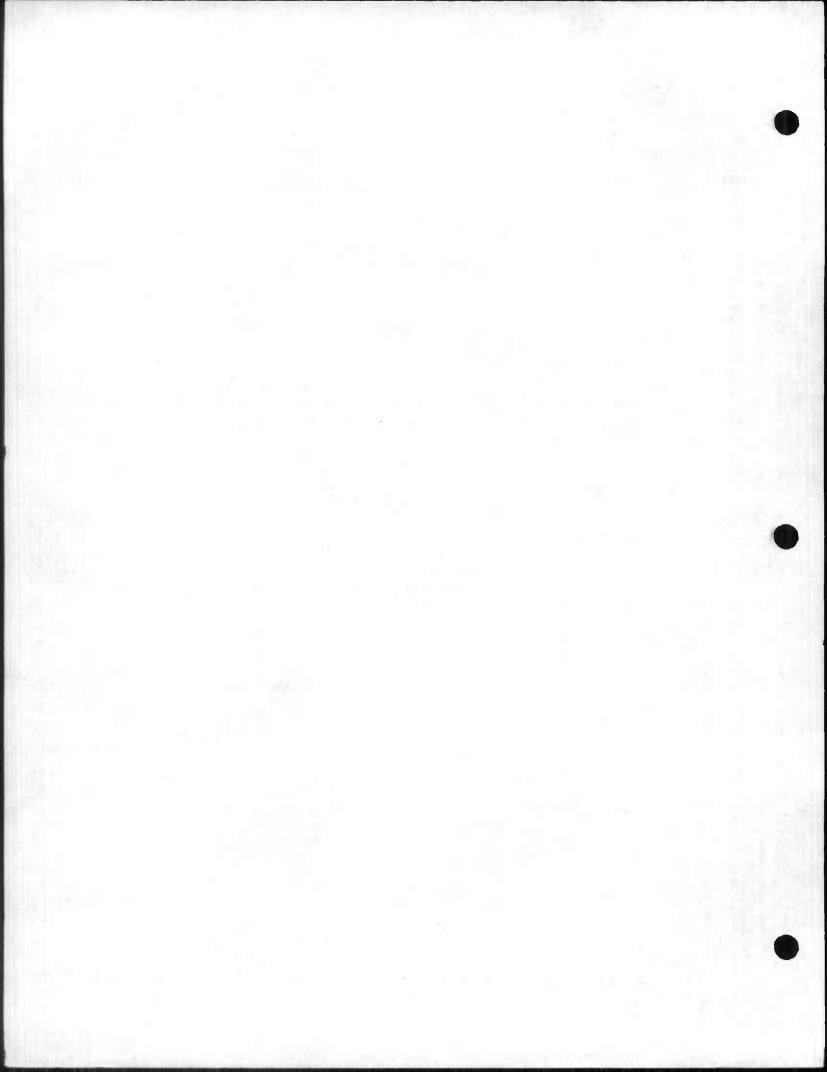
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ral	5. Sociel Security		. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Yee	r If Under 24 Hr	8. Data of Bir			lace (State or Foreign	
tor	216-96-2	2074	1 M 2 □ F		30°rs.	Months Days	s Hours Min	04-16-1		RUSS I	[A	
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ŏ	TOB. Stele	100. County		100. 011	y, TOWN OF LOC	stion					0d. Inside City Limits 1 ☐ Yes 2 No	
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Ö			ATOM A DOUBLE	1 1					USA	rviioi Couri	niy i	
Funeral	9 FEATHE		OURT APT#1	ant Evar in U,	S. 13. W	20904 es Decedent of	Hispanic Origin? (Specify Yes or No		e - America	an Indien,	
by Fur	1 Never Me	rried 2 Merried	Armed Forc 1 Yes 2 If Yas, Giva Yeer or Det	X No		Yes, specify Cul ☐ Yes 2 No	Hispanic Origin? (.ban, Mexican, Pue Specify:	rto Rican, etc.)	Specify	ok, Whita, o		
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Physician/Medical Examiner	rasulting in death; Sequentially list c if any, leeding to i cause. Enter Und Cause (Disaese o that initieded even resulting in death)	conditions, immediate Jerlying or Injury ts	b	Dua to (or	r es a consequer as a consequer as a consequer	Musc ence of):	LILURY	ystne	ррну	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
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E								10	Yas 2 No	10	Yes 2□ No	
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10	examiner? 1 ☐ Yes 2)⊠	1 No	Hospital:	etient 2	ER/Outpatient	3 DOA O	ther: 4 Nursing	Home 5 Rasi	dence 8 Oth	er (Specif)	y)	Ī
Certification:	27. Mannar of Dea 12 Naturel 2 Accident	5 Pending invastigation	ion	Injury Day Year)	28b. Tima of Injury	28c. Inj W	ury at ork?] Yes 2 No	28d. Dascribe	how injury occur	red		
artine .	3 ☐ Suicide 4 ☐ Homicide	6 Could not datermine	ZOU. FINCE OF	Injury - At ho , etc. (Specify	me, farm, stree	et, factory, office		28f. Location (City or To	Street and Numb wn, State)	per or Rura	Il Routa Number,	
Ö		Ocadhian C	Physician: To the be	s of examinat	wledge, death of	occurred at the t	time, dete end plac	e, end dua to tha	cause(s) and ma	anner as st	ated.	
edical C	29e. Certifier (Check only one)	2 Medical Ex	and menne	r steted.		atigotion, in my	opinion, dualit ood					
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Medical	(Check only one) 29b. Signeture and 200. Name and edd	2 ☐ Medical Exact title of certifier frame of person who HAEL SIR	Lubt	of death (Item	M ()	29c. Licer	nse number C / 4 D	63	29d. Deta signe		Day, Year)	

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State of Maryland / Department of Health and Mental Hygiene

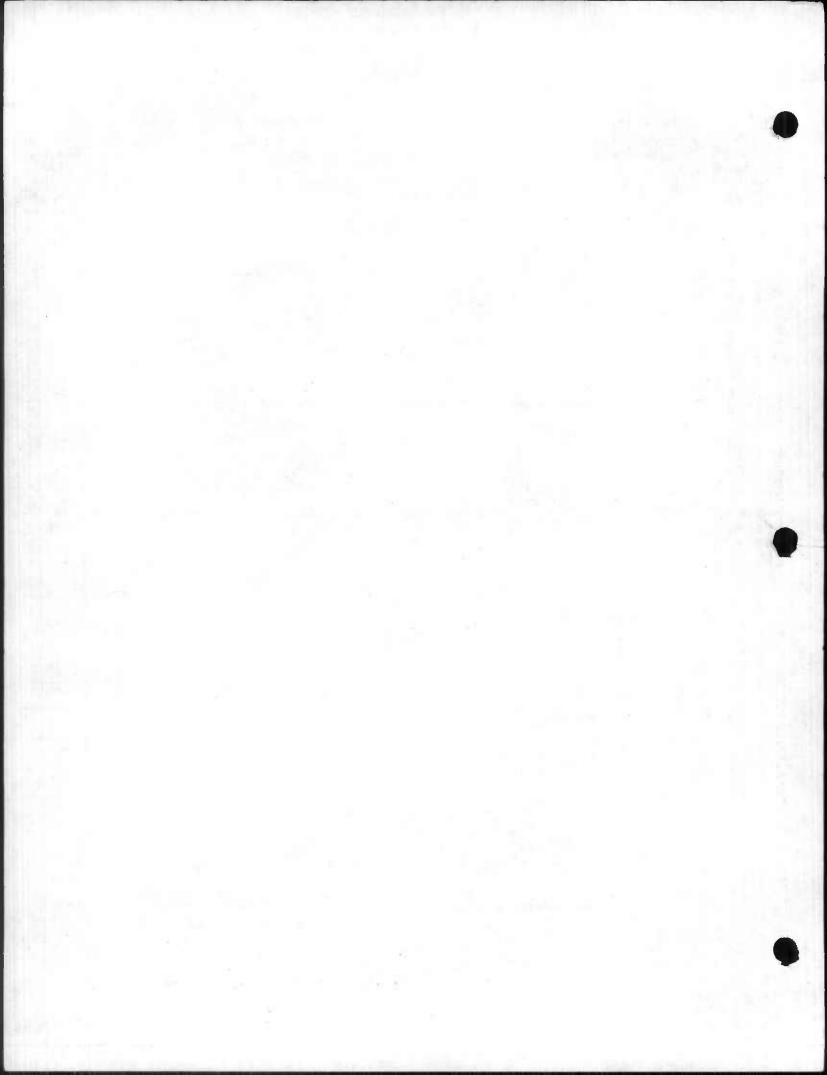
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year **Physician** Mildred H. Leffel November 5, 2000 12:35 am /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stetle Country) March 20,1923 Virginia 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Deys 1 M 2 XF 77 Yrs 226-28-1324 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits show the Maryle 1 Nas 2 No Director Maryland Montgomery 28a-f Rockville 10a Street and Number 10f. Zip Code 10g, Citizen of What Country? iner must be n 4608 Aspen Hill Court 20853 USA Funeral 11 Marital Status 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. should be filed within 72 hours after ond Mental Hygiene.
Imarked other than "natural", or life imatic event, the Medical Examiner in "natural", or lise Madical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: White à 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Telephone Operator Montgomery Wards 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be fitted that the second of the seco Be Alvin Hatcher Goldie Richardson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Intorment's Neme/Reletionship (Type, Print) Cherri Bean / Daughter 4608 Aspen Hill Court, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20c. Location - City or Town, State Dete Important: It any injury o 9059. 11/10/00 Troutville, VA Department Troutville Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Fecility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funerel Service Licenses Cond 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Renal Insufficiency 1 week Examiner Due to (or as a consequence of): Examiner Congestive Heart Failure 2 years ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): physician s the burial Box 68760. Coronary Artery Disease 17 years Physician/Medical Dua to (or as a consequence of): 88 signed by the at d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 Unknown Chronic Obstructive Lung Disease Records. py 24b. Were eutopsy tindings evailable prior to Completed 24a. Wes an autopsy parformed? Diabetes completion of cause of death? page 2 1 Yes 2 No 1 Tes 2 No Division of Vital Attending Physician: 25. Wes case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation death. 1 Yes 2 No Hospital or Attending
 24 hours after death
 Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, tarm, atreet, fectory, office building, etc. (Specify) filled in by 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier Medicai within 24 hor To the Fune completely fi (Check only one) the th 29b. Signature end title of curtifier 29c. License number 29d. Date signed (Month, Day, Year) 0 per and rose 12 00 CROSSBERG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2415 Musgrove Road, #307, Silver Spring, MD David Grossberg, MD 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

2000

NOV 06

Registrar



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tate of Maryland / Department of Health and I	Mental Hygiene	7 40
Certificate of Death	Reg. No.	
	2. Data of Death	3. Tima of Death

ROCKVILLE

Physician
/Medical
Examiner

LEWISTON 4e Facility Neme (If not institution, give street and number)

1. Decedent's Name (First, Middle, Last)

Month 11 4b. City, Town, or Location of Death 9:30PM

10d. Inside City Limits

1 Yas 2 □ No

5. Social Security Number 578-01-0200

6 Sex 1□ M 21 F

HEBREW HOME OF GREATER WASHINGTON

7. Aga (In vrs. last birthday) 90

If Under 1 Yaer | If Under 24 Hrs. Months Deys

8. Dete of Birth (Month, Day, 09 24

Dey 03

9. Birthpiaca (Stata or Foreign MARYLAND

Funeral Director

9

72 hours after

filed within

Maryland 21215-0036

Baltimore,

Physician /Medical

Examiner

attending physician and for use as the burial-transit

signed by the a

peen : page 2 certificate has

funeral director,

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filled in by

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within 24 hours after death. To the Funeral Director: After

The law requires that the death certificate be asscuted

Box 68760

Division of Vital Records, P.O.

or Attanding Physician:

Hospital

To the

Examiner

Physician/Medical

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Completed

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Certification: To

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10a State Directo Funeral

ed other than "natural", or Nems 23s or 28s-f show event, the Medical Examiner must be notified as permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Importants if flem 27 is marked other th any fritury or other transments.

Usual Residence of Decedent by Completed 80

10b County MONTGOMERY 10e. Street and Number 9116 COPENHAVER DRIVE 10c. City, Town or Location POTOMAC

10f. Zip Code

20854

10g. Citizen of What Country? U.S.A.

2000

4c. County of Death

MONTGOMERY

11 Meditel Status 1 Never Married 2 Married 3 Ø Widowed 4 □ Divorced

12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Detes:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1□ Yes 2□ No Specify

Bleck, White, etc. Specify: WHITE

14 Bace - Amarican Indian

15. Decedent's Education (Specify only highast grada complated) Elementery/Secondary (0-12)

Cotlege (1-4or 5+)

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) HOMEMAKER

16b. Kind of Business/Industry OWN HOME

17. Father's Name (First, Middle, Last)

FRIEDMAN ISAAC

18. Mother's Neme (First, Middle, Maiden Sumame)

IDA

19e. tnforment's Name/Relationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9116 COPENHAVER DR, POTOMAC, MD 20854

ELAINE GOLDBERG

Niece

20b. Plece of Disposition (Name of cemetery, crematory or other place)

22. Neme end Address of Facility

20c. Location - City or Town, Stete Dete

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 🖾 Removel from State

OHEV SHOLOM CEMETERY

11-5-2000 WASHINGTON, DC

21. Signeture of Funerel Service Licensee

4 ☐ Donetion 5 ☐ Othar (Specify)

Horald W. Kevenber

DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

SEPSIS

Due to (or as a consequence of)

3 DAYS

Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

Due to (or es a consequance of):

Due to (or as e consequenca of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

ALZEIMERS DISEASE

1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed?

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 Yes 2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminar? 1 Yes 2 No 27. Menner of Death

5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of tnjury (Month, Day Year) 28b Time of

28c. Injury at Work? 1 Tyes 2 No

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only

1. Neturel

2 Accident

3 ☐ Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steled.

28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

29b. Signatura and title of certifier

29c. License number 05885 29d. Date signed (Month, Day, Year) 00

28f. Location (Street and Number or Rural Route Number, City or Town, State)

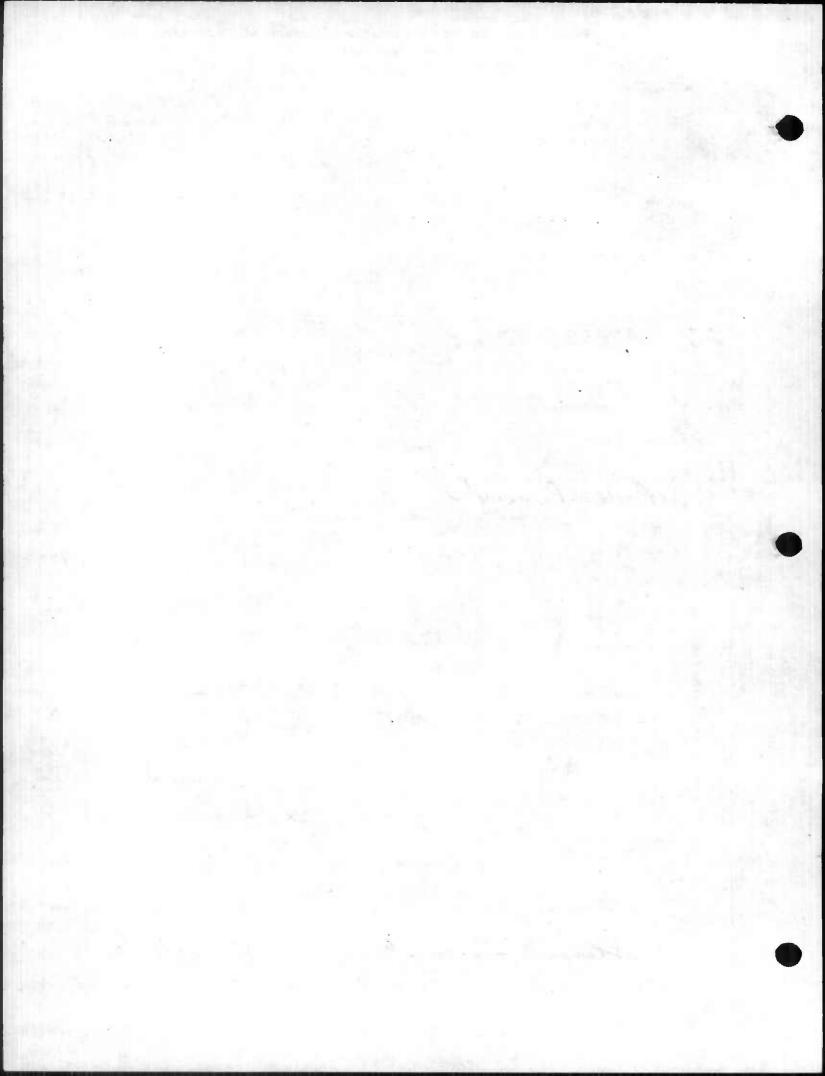
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONTROSE ROTD, ROCKVILLE, MD 6121 LIPSON EVEN

State Registrar 31. Date filed (Month, Day, Year) 06 2000



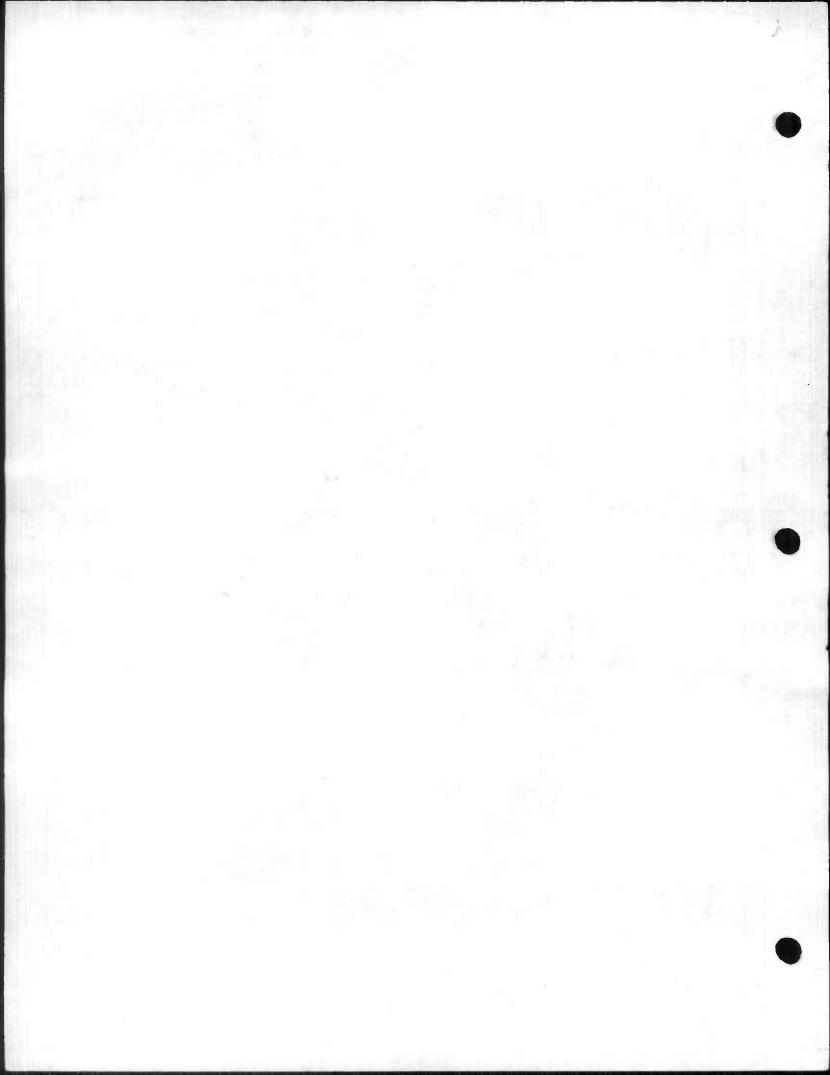
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State of Maryland / Department of Health and Mental Hygiene

	_	Decedent's Ner	me (First, Middle	, Last)						Death	2.	Date of Dee			3. Time of Death
sician edical		Isaac Wickham McGlothlin					N	Month Iovembe	er 13,	2000	3:30 am				
miner	4.	Facility Neme	(If not institution,	give stree	et and num	iber)				4b. City, Town,	r Locat				
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ctor	M	Maryland Cecil					Colora					1 □ Yes 2 🖺 N			
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Funeral Director	11	1. Meritel Stetus			Nes Dece	lent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl			(Specif	pecify Yes or No-		U.S.A. 14. Race - American Indian,			
Š		1 Never Me	rried 2/XMerrie	ed 1	Armed Fore	ces?		If Yes, spe 1□ Yes		Specify:	erto Ric	an, etc.)	Speci	ack, White,	
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du		Elementary/Sec Seven Y	condery (0-12)	Ť	College (1-	4or 5+)	life.	Weld		during most of (d)				ocal 193 altimore, Maryland	
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TOB			Geor	rge M	cG1ot	hlin					Ma	rtha J	Jackson		
	18		Neme/Reletionsh							and Number or					-
	-	Marie I	. McGlot	thlin		20h	2025 Place of Dispo			way, Co	1		20c. Location	2191	
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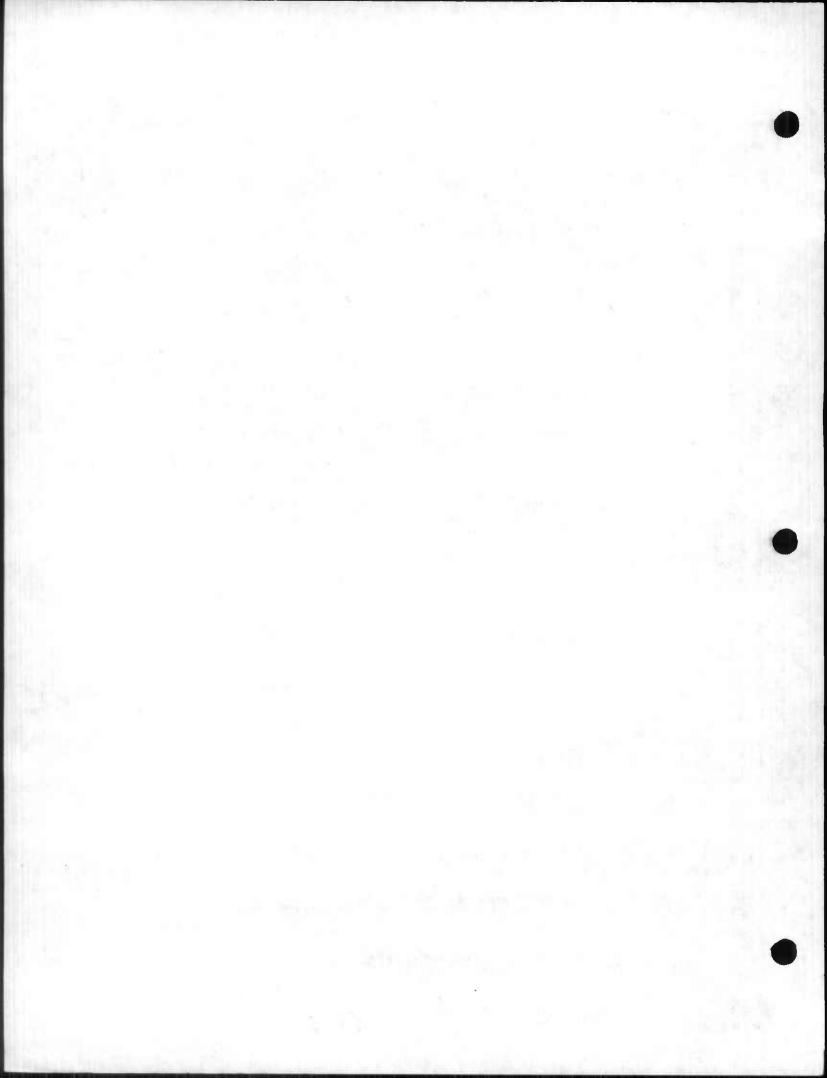


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State of Maryland / Department of Health and Mental Hygiene

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			Certificate of	Death	Re	g. No.	01112	
	1. Decedent's Nama (First, Middle, Last,). 3	,		2. Dete of Death	Day	3. Time of Death	
Physician	ANTHONY D	ONELL M	1445		Month OCTOBER		Yeer 000 9:00 AM	
/Medical Examiner	4e Facility Name (If not institution, giva		1000	4b. City, Town, or I	ocation of Deeth	4c. County o	f Deeth	
Examine.	PENINSULA REGIONA	AL MEDICAL CENTE	ER	SALISBU	RY	WICC	OMICO	
Funeral	Sociel Security Number 6. S		oirthday) If Undar 1 Yaar	If Under 24 Hrs. Houra Min.	8. Date of Birth (Month, Dey,	Vanel	9. Birthplece (State or Foreign	
Director	217-90-1431 19 Usual Residence of Decedent	M 20 F 29	Yrs. Months Days	Houra Min.	9-28	-7/	Country) M.D.	
within 72 hours effer deeth with the Maryland ene. Than "naturel", or frems 23e or 28e-f show the Medical Examinar must be notified at empleted by Funeral Director	10a. Stete 10b. County	10c. City, To	wn or Location				10d. Inside City Limita	
To To	Mr. Wiche	11co S	ALISBURY				Yea 2□No	
or 28s-f a be notified Director	10e. Street and Number		10f. Zip Code		10	g. Citizan of Wi	hat Country?	
al D	FAST FITZ	WATER ST.	21	801		17	SA	
ef, or items 23s or 28s-f show Essention must be notified at by Funeral Director		12. Wes Decedent Ever in U,S. Armed Forces?	13. Was Decedent of H	dispanic Origin? (S	pecify Yea or No-		- Amarican Indian, . White, etc.	
F 1	1 Never Merried 2 Merried	1 Yas 2 'No	1 Yes 2 No		o riiodii, ato.,			
by	3 Widowed 4 Divorced	Yaar or Detas:	1 LI 165 2 Jan 140	Specify.		Specify:	BLACK	
t, the Medical East Completed by	15. Decedent's Edu (Specify only highast gred		a. Decedent's Usuel Occup (Giva kind of work done	pation during most of war	king	6b. Kind of Bus	siness/Industry	
	Elementery/Secondery (0-12)	College (1-4or 5+)	life. DO NOT use retire	d)		7	- T	
sumatic event, the Manualic event events are the manual events	12		EVISERA				RDUE LAC.	
aven Be	17. Fathar's Nama (First, Middle, Last)	41		18. Mother's Nan	ne (First, Middle, M.	aiden Sumeme)	
iem 27 is marked other than other traumatic event, the M To Be Comp	DONALD LEE	MILLS		MAE H	ELEN GI	RAHAM	MILLS	
5	19e. Informent'a Name/Reletionship (Ty	rpe, Print) 19	b. Meiling Address (Street	end Number or Ru	ral Route Number,	City or Town, S	Stete, Zip Code)	
om 27 ther tr	MAE HELENG. MIL	LS-MOTHER :	27490-EDGE	WOODC	RCIE SAL	ISBURY	MD. 21801	
	20a. Method of Disposition	20b. Place	of Disposition (Neme of ery, cremetory or other ple		Dete 2	Oc. Location	City or Town, Stete	
T O	1 Buriel 2 ☐ Cramation 3 ☐ F		SHILL CEME	TARY !	ululano	HEBI	RON. MD.	
Injury	21. Signature of Furgeral Service Licens		22. Neme end Addre	ess of Fecility	FUNE S	MITH F	14	
Fig (1201	1					010 016 01	
1000	23a. Part Enter the disease, or compl	ications that caused the death. D			ST. SALL		MD. 21801 Approximete	
	shock, or heert feilure. List only or	ne ceuse on each line.	, 1101 011101 1110 111000 01 0,1		or roopmotory and	- 1,	Intervel Between Onset and Deeth	
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nin nin		b					i	
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the burial-trensit dical Examir	cause. Enter Underlying Cause (Disease or injury	c						
edical	that initiated events resulting in death) Last	Due to (or es e	consequence of):					
• ≥		d						
Physician/								
detached for	Part II. Other significant conditions cor	ntributing to death but not resulting	In the underlying cause gi	van in Pert I.	23b. Did tob		tribute to the cause of death?	
P. P.					1 □ Ye	• 22 No	3 Probably 4 Unknow	
5							OAL Mary Control of the Control	
eted					24a. Was an perform		24b. Were autopsy findinga evailable prior to completion of causa	
N Q							of death?	
TO.					12 Yes	s 2□ No	1 Yes 2 No	
Be (25. Wes case referred to medical			26. Place of Dec	eth (Check only one)		
÷ 0	examinar?	fospitel: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 DOA Oth	her: 4 Nursing h	loma 5 ☐ Resider	nca 6 Othe	r (Specify)	
n:]	27. Menner of Death	28a. Dete of Injury (Month, Dey Year) 28b	. Time of 28c. Inju	ry et			ed Subject was	
e fur	1 Netural 5 Pending 2 Accident investigation	1		Yes 2 No	Collision	with m	and had a potor vehicle	
FIC BY	3 Suicide 6 Could not be determined					Location (Street and Number or Rure) Route Number, City or Town, Stete) Carroll Street Route 13		
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pletely fil	(Check only 2 Medical Examination)	ner: On the basis of examinetion e and menner steted.	end/or investigetion, in my	opinion, deeth occu	rred et the time, da	te end pleca, a	nd due to the ceuse(s)	
Completely filled in by the funeral Medical Certification: 1	29b. Signatura end titla of cartifier		29c. Licens	se number	29d. Dete signed (Month, Dey,		(Month, Dey, Year)	
0	1 st. 11	A 1/1	7 410	.C.M.E.		OCTORE	R 31, 2000	
2	20 Name and add //	1 Vinole	1014	- J.11. LI.		OCTOBBI	31, 2000	
141	30. Nama and eddresa of person who co	1			+ ·	(awv) av	3 21201	
-	31. Dete filed (Month, Dey, Year)	a dent 2, 32. Registrer'a Signature	111 Penn St	reet, Bal	Limore, N	arylan	1 21201	
State Registrar	NOV 0 2 21	100 Separature	B. Som					
DISTRIBUTE OF THE PARTY OF THE	1101 0 10 11	JUU	10. 161100	1. 1				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month Year **Physician** Eddie Mack November 7,2000 13:35am /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veterans Home Charlotte Hall St. Marys If Under 1 Year 8. Date of Birth
(Month, Day, Year)
March 25,1941
South Carolina 6. Sex 1 → M 2 □ F Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Yrs. Director 247-64-0992 59 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Baltimore Randallstown 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Herns 23a 3834 Elmcroft Road 21133 U.S.A death Funeral 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 72 hours after 1 Types 2 No If Yes, Give Yeer or Detes: 1959-62 1 Never Merried 2 Memied altimore, Maryland 21215-0020 "natural", or Specify: Black 1 ☐ Yas 2 ☑ No Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland Veterans Hygiene. Elementery/Secondery (0-12) Collega (1-4or 5+) Training Center Cook 12 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be nent of Health end Mental int: If Itam 27 is marked or Thelma Polite Eddie L. Mack 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) : If item 27 is r or other tra Julia D. Mack /Wife 3834 Elmcroft Road, Randallstown Maryland 21133 20a. Method of Disposition 20b. Place of Disposition (Nema of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Steta permit. Page Department of Important: If any injury or page. Baltimore National Cemetery 11/13/2000 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Neme and Address of Fecility Estep Brothers Funeral Service Baltimore, Maryland m190 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiec or respiretory errast, shock, or haert feilure. List only one cause on each line. Physician PANCREATIC CAMER /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Examiner be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in daath) Lest and Dua to (or es e consequence of): 68760 physician Physician/Medicai the Due to (or es e consequence of): Box Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I 23b. Did tobacco use contribute to the cause of death? o 3 1 Yes 2 No 3 Probably 4 Onknown signed to þ 24b. Wara eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Vital Attanding Physician: Be 25. Was case raferred to medical 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA of this 28e. Dete of Injury (Month, Day Year) 27. Mennar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor 6 Could not be determined 3 Suicide 28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 124 hours after die Funeral Diract 4 Homicide ò Hospital edical 29a. Certifian Certifying Physician: To the best of my knowledge, daeth occurred et tha tima, data and place, and dua to tha causa(s) and manner as stated. To the Funer completely fi 2 Medical Examiner: On the besis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated. (Check only one) To the Within 2 To the

State Registrar

31. Dete filed (Month, Dey, Year) NOV 1 4 2000

29b. Signeture and title of certifian

30. Nema end addres

ss of person who completed cause of death (Itam 23a) (Type, Print) 32. Ragistrar's Signatura

6BPRESTON S&TI WARDORFNO 20602

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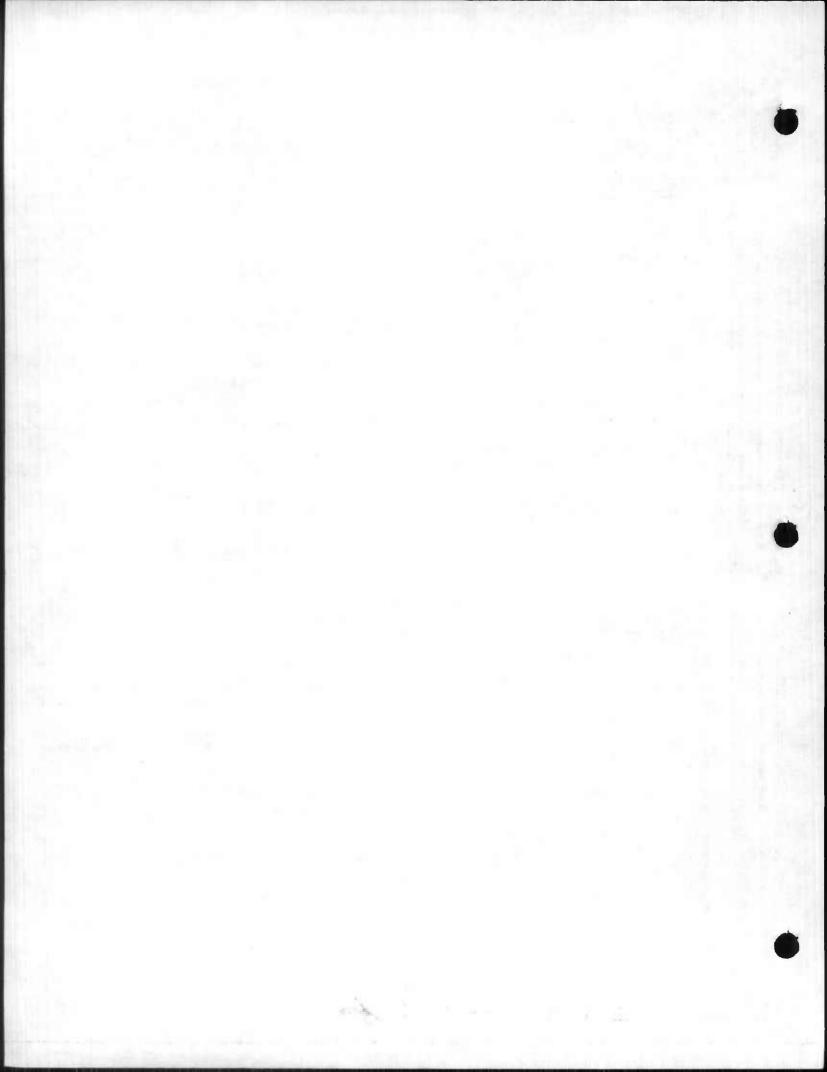
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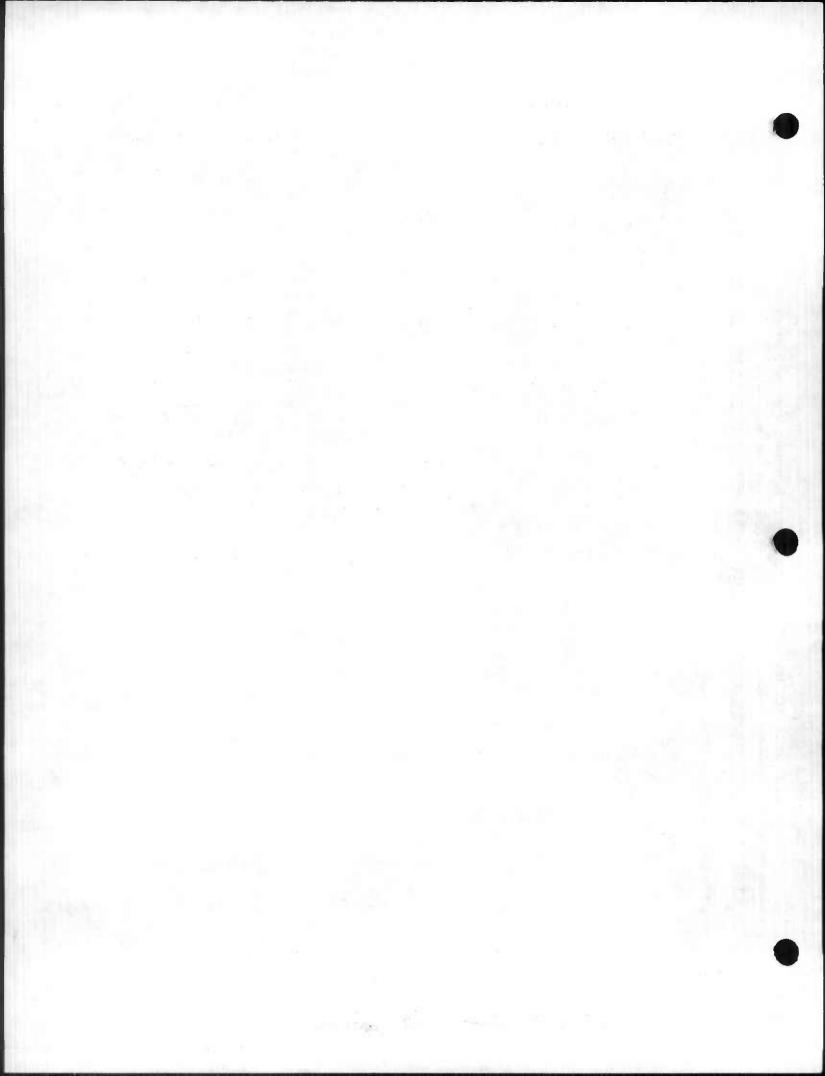
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NAME: GEORGE P. MARGELOS

		State of Maryland / Department of Health a Certificate of Death		giene Reg. No.	37144						
	Physician /Medical	Decedent's Name (First, Middle, Last) GEORGE PETE MARGELOS	NOVEMB	2. Date of Death NOVEMBER Day 2, 2000 8:00PM							
	Examiner	ST. MARY'S HOSPITAL LEONA	n, or Location of Death	TOWN ST. MARY'S							
	Funeral Director	5. Social Security Number 577-24-6967 Usuel Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 8. Hours 9. Hours	Min. 8. Dete of Bin (Month, Da APRIL 8	, 1924	9. Birthplece (State or Foreign WASHINGTON D. (
	Maryland a-f ahow shed.at	10a. State 10b. County 10c. City, Town or Location WARYLAND CHARLES WALDORF			10d. Inside City Limits 1 ☐ Yes 2 ☑ No						
	ath with the Merylan 123e or 28a-f show nest be notified at 17af Director	10e. Street and Number 10f. Zip Code 1004 TYLER COURT 20602		10g. Citizen of U.S							
020	urs after de af, or item Example: D	11. Manital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Agned Forces? 1 Yes 2 No If Yes, specify Cuban, Mexicen, In Yes, Sipe Year or Dates: 13. Was Decedent of Hispanto Original If Yes, specify Cuban, Mexicen, In Yes, Sipe Year or Dates: 14. Was Decedent Ever in U,S. Agned Forces? 15. Was Decedent of Hispanto Original If Yes, specify Cuban, Mexicen, In Yes, Specify: 16. Was Decedent of Hispanto Original If Yes, specify Cuban, Mexicen, In Yes, Specify: 17. Was Decedent of Hispanto Original If Yes, Specify Cuban, Mexicen, In Yes, Specify Cuban, Mexicen, In Yes, Specify: 18. Was Decedent of Hispanto Original If Yes, Specify Cuban, Mexicen, In Yes	in? (Specify Yes or No Puerto Ricen, etc.)	(Specify Yes or No- erio Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. Specify: WHITE							
21215-0020	within than "than "me Man	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) PLUMBER	of working	RESIDENTIAL PLUMBING							
Maryiand	should be filed and Mental Hygis marked other smalls avent, to To Be Co		s Neme (First, Middle, CGINIA GRIM		ne)						
	and 2 sho aalth and In 27 is ma	PEGGY A. MARGELOS/WIFE 19b. Meiling Address (Street and Number 1004 TYLER COURT, W			, State, Zip Code) 20602						
	nit. Pages 1 anment of Hi ortant: if Iten Injury or ott 8.	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State 4 Donation 5 Other (Specify) TRINITY MEMORIAL GARDEN	Date 11/17/20		ORF, MARYLAND						
Ball	permit. Pag Department Important: i any injury o	P.U. BUX 130, WA	LDORF, MAR	YLAND	20604-0156						
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as conshered, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Due to (or es a consequence of):			Approximate Interval Between Onset and Deeth 310 Vorw						
	death certificate be assected a attending physician and of for use as the burist-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or es a consequence of):									
P.0	y the	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. Previous CVA		23b. Did tobacco use contribute to the cause of							
ecord	shoul	Azhemei's disease		an eutopsy ormed?	24b. Were autopsy findings available prior to completion of cause of deeth?						
Vital R	delan: The lav certificate has rector, page 2 Be Comp	examiner? Mosnital: \ Other	of Deeth (Check only o	one)	1 □ Yes 2 □ 🖟 0						
SION Of seath. or: After this the funeral di	eath. or: After this the funeral di cation: To	1 Yes No Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursell Nu	28d. Describe	ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)							
	Hospi 24 hour Funer staly fill dical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) end menner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated.									
	To the compla										
		30. Name are selected east of person who completed ceuse of deeth (Item 23a) (Type, Print) JENNIFER SCHMIDT HOLLYWOOD, MD. 20	636								
	State Registrar	31. Date filed (Month, Day, Year) NOV 1 4 2000 32. Registrar's Signeture									

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MacSorley Bruce Hodason 2000 8:55 pm November 8 /Medical 4e. Fecility Name (II not Institution, give street and number) 4b. City. Town, or Location of Death. 4c. County of Deeth Examiner The Hospice House Easton Talbot | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Aug 30, 1931 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** M 2□ F Yrs. Director 69 Maryland 213-24-4663 Usual Residence of Decedent death with the Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show maint be notified at Yes 2 No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 238 505 Maryland Avenue 21613 HS by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 275 No If Yes, Give Year or Detes: **Нета** 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. traumatic event, the Medical Examiner filed within 72 hours after 1 □ Never Married 2 □ Married 21215-0020 ŏ 1 ☐ Yes 2 No Specify: White Specify: natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Broker Real Estate other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be h end Mental F Pages 1 end 2 should be nent of Health end Mental Fred Carlton MacSorley Beulah Hodgson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) of Health of Item 27 Is other 1 Marjorie S. MacSorley P.R. 505 Maryland Avenue Cambridge, Maryland 21613 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or once. = 0 11/10/00 Salisbury Crematory Salisbury, Maryland 21. Signatu Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home PA more 700 Locust St. Cambridge MD 21613 23a. Perfu Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Metastatic Lung Concer /Medical immediete Cause (Final 3 Moulls disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest pug Due to (or as a consequence of): Box 68760, physician Physician/Medical the Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? signed by 1 Yes 2 No 3 Probably 4 □ Unknown Division of Vital Records, p page 2 should be 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy performed? peen completion of cause of death? this certificate has 1 ☐ Yes 2 No 20 No or Attending Physician: Be (director, 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No funeral 27. Manner of Deeth 28d. Describe how injury occurred CENTER Certification: 28b. Time of 28a. Date of injury (Month, Dev Year) 28c. Injury et Work? After 1 Matural 5 Pending investigation s effer dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rure! Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide e Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier Medical 29b. Signeture and title of certified Vaccini 29c. License number 29d. Date signed (Month, Dey, Year) 11-9-00 D 47924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 NOMAN THANKY CAMBRIDGE MD 2/6/3 AURORA

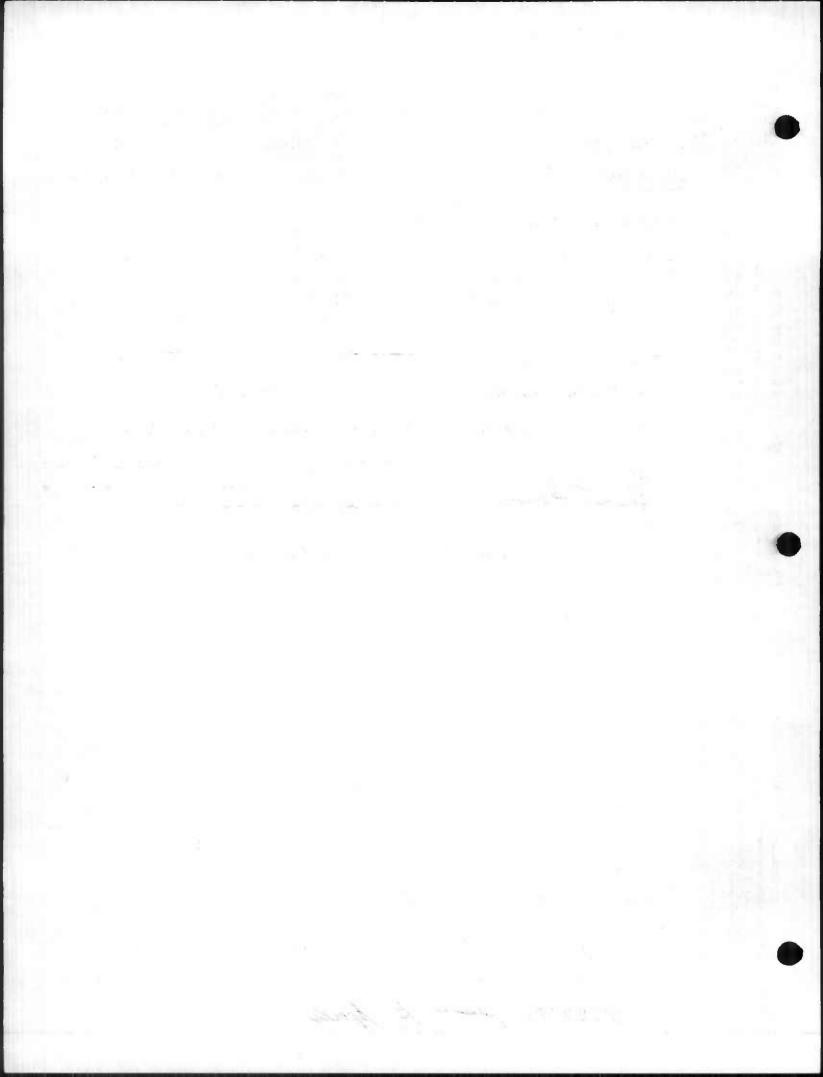
DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Year)

NOV 0 9 2000

32. Registrar's Signeture

Doneh



Please

10f. Zip Code

Homemaker

21617

1 ☐ Yes 2 No Specify:

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)

10c. City, Town or Location

Centreville

12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give Yeer or Detes:

College (1-4or 5+)

/ Granddaughter

who completed ceuse of death (Item 23e) (Type, Print)

32. Registrer's Signeture

Ple		Print in Black Indelible						7116
	State	of Maryland / Department Certificate				ene g. No.	JU J	1146
1. Decedent's Neme (First, Mid Rosalie M.	dle, Last) Martin				2. Dete of Deeth Month October	1	2000	3. Time of Death 5:30AM
4a. Fecility Neme (If not institute Corsica Hills				4b. City, Town, or L Centrevi			unty of Deeth	e's
5. Sociel Security Number 118-09-2362	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. lest birthday) If Under Months	1 Year Deys			Yeer) 1910	9. Birthp Coun	elece (Stete or Foreign etry)

10d. Inside City Limits

10g. Citizen of Whet Country?

14. Race - American Indian, Bleck, White, etc.

Specify: White

16b. Kind of Business/Industry

U.S.A.

Self.

18. Mother's Neme (First, Middle, Meiden Sumeme)

D. Daraho Dive Chesher, MD 21619

Lillian Winfield

100 Somerset Road Stevensville, MD. 21666

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

1 XYes 2 No

Funeral Director

Physician

/Medical

Examiner

10e. Street end Number

10a. State

MD

Director

Funeral

þ

Completed

Usual Residence of Decedent

10b. County

205 Armstrong Street

1 Never Merried 2 Married

3 Widowed 4 □ Divorced

Elementery/Secondery (0-12)

Unknown

Lynn Rehn

17. Father's Neme (First, Middle, Last)

19e. Informent's Name/Relationship (Type, Print)

Queen Anne's

15. Decedent's Education (Specify only highest grade completed)

the Maryland item 27 is merked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified as

permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a. ŏ

Physician /Medical **Examiner**

-362

-608115

Box 68760

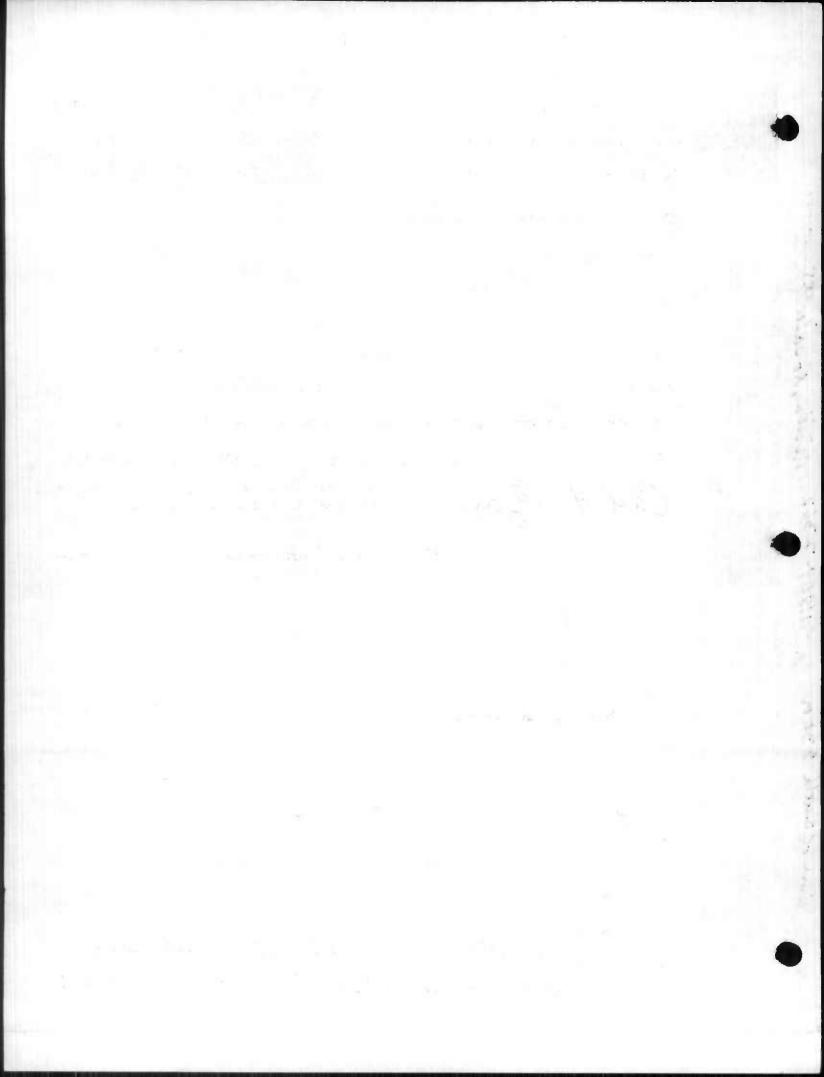
Division of Vital Records,

the burial-transit and Be Completed page 2 certificata Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica To the Hospital or within 24 hours aft To the Funeral DI completaly filled in

20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) St. Peter's Cemetery Poughkeepsie, N.Y. 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road Chester, MD. 21619 Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one could not each line. Onset end Death Myocardial infantion Immediate Ceuse (Finel disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? Multi, which dementia 1 Yes 2 10 3 Probably 4 Unknown λq 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: Surring Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Dev Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one) ြ Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture and title 29c. License number 29d. Date signed (Month, Dey, Year) 032036

State Registrar 30. Name and address of person

31. Dete filed (Month, Dey, Year)
OCT 2 5 2000

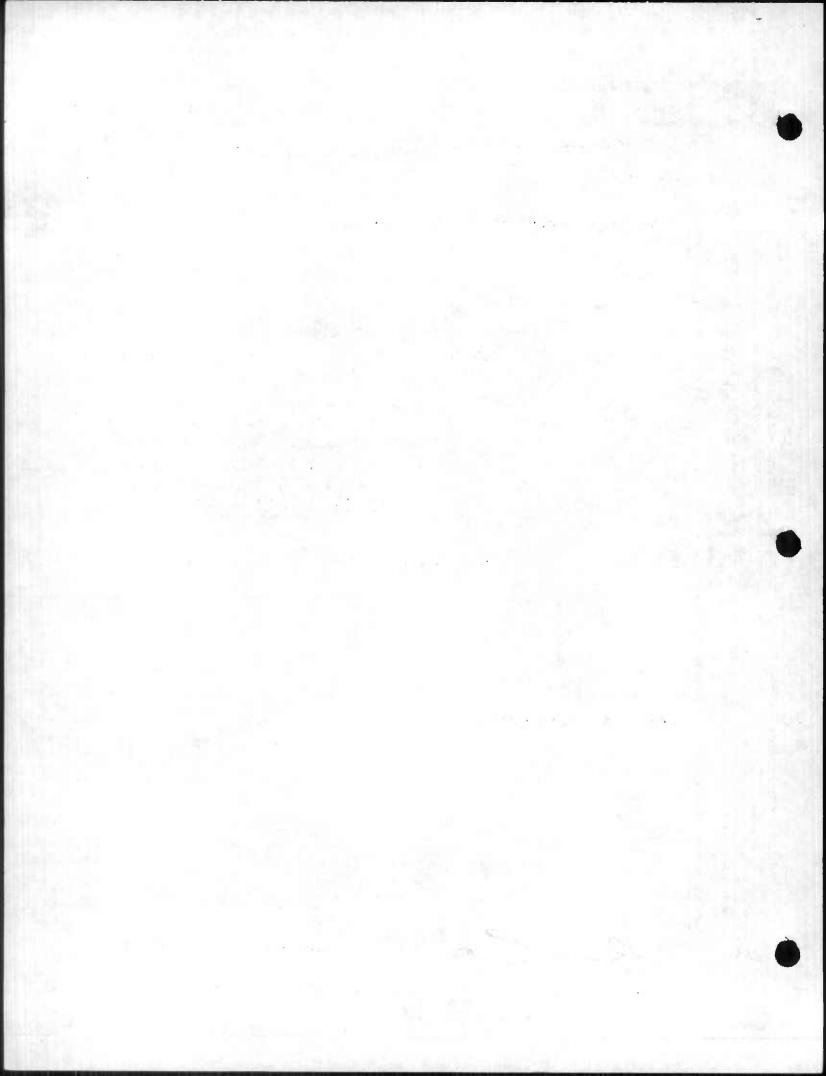


					C	ertificate	e of L	Death			Reg. No.		
L.	1. Decedent's Name ((First, Middle, La	st)			S TOWN	1			2. Date of De	eath Dev	Year	3. Time of Death
Physician /Medical	Albina	Ann		Mille	er		3.5			Novemb		2000	8:00 AM
Examiner	4a Facility Name (If n	not institution, giv	e street end nu	imber)			4	b. City, To	wn, or Lo	cation of Deat	h 4c. County	of Deeth	
	Mariner H	-		0					singt			ntgom	
uneral	5. Sociel Security Nun		Sex I□M 2\IF	7. Age (In yrs. 94	last birthda Yrs.	y) If Under Months	Deys	If Under :	Min.	8. Dete of Bir (Month, Da			lace (Stete or Foreightry)
irector	578-52-041 Usual Residence of D	14	71.	74	110.					Jan. 2	1, 1906	Mont	tana
B m		10b. County		10c. C	ity, Town or	Location						11	0d. Inside City Limi
Start sho notified at rector	Alaska	(Unava	ilable)		F	airban'	ks					111	1 ☐ Yes 2 🂢 N
	10e. Street and Numb					101. Zip					10g. Citizen of V	What Coun	itry?
40 000	518 Fult	ton St.					99	701			United	Stat	es
diner must funeral	11. Maritel Status		12. Was Dec	edent Ever in U	J,S. 13	3. Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	0- 14. Rac Blac	e - Americ	
y F.	1 Never Married		1 TYPes If Yes, G	8/0		1□ Yes 2					Specify		
al Exam	3 ☐ Widowed 4		Yeer or E	Detes: 1943	1		10	41.00				W	hite
wer than "naturn it, the Medical I Completed	(Specify	5. Decedent's Ed only highest gra	ide completed)		16e. Dec	cedent's Usue ve kind of wor . DO NOT us	rk done d se retired	ation <i>furi</i> ng most 1)	of working	ng	16b. Kind of B	usiness/inc	dustry
the M	Etementery/Second		College (Unavai)	1-4or 5+)		ier / 1					II S A	rmed	Forces
d other event, Be C	17. Father's Neme (Fi			au I C		, ,				-	, Meiden Suman		202000
Page 0	Frank			Mi	ller			Mai	су		Marl	har	
	19e. Informent's Nam	ne/Reletionship (Type, Print)	-	19b. Me	iting Address	(Street	and Numbe	or Or Rura	l Route Numb	per, City or Town,	State, Zip	Code)
127 les Uni	Emma Warwi	ick / Si	ster		518	Fulto	n St	., Fa	iirba	inks, A	K 99701	-3036	
the state of	20a. Method of Dispos 1 ☑ Burial 2 ☐		Damoual from		Place of Dis	position (Nem	ne of ther plac	e)	No	Date OV. 14	20c. Location -	City or To	wn, State
ortant: If injury or 8.	4 Donetion 5				lingt	on Nat	iona	1 Cem		2000	Arling	ton,	VA
y inj	21. Signeture of Fune	erel Service Licer	остро			22 Name an	d Addres	s of Facilit	y , (icoc	
5 5 8	1	11/11/	111				rume	13 2	311(1)	remati	on Serv		
	CEIN	beilt do	turn	an	1	Steph	rune ien D	Lot	rmar	n P.A.	on Servi	20	910
	23a. Pert1. Enter the shock, or heert t	diseese, or com feiture. List only	plications thet	caused the dea	th. Do not e	Steph 933 G	en Dist	Lol Ave., g, such es	nrmar Sil	remati in P.A. ver Sp	on Serving, MI	20	910 Approximete Intervat Between
sician	SHOCK, OF HEER L	rendre. List only	plications thet one cause on	caused the dea	th. Do not €	Steph 933 G	rune ien D ist e of dying	Lol Ave., g, such es	nrmar Sil	rematin P.A. ver Sp	on Serving, M	20	Approximete
edical	Immediete Ceuse (Fit	rendre. List only	One cause on	caused the dea				Lol Ave., g, such es	nrmar Sil	rematin P.A. ver Sp	on Serving, MI	20	Approximete tntervat Between
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Is been signed by the attending physician and 2 should be detached for use as the burial-transit application of the property	Immediate Cause (Fis disease or condition resulting in death) Sequentially list cond if any, teading to immediate. Enter Underly Cause (Disease or in that initiated events resulting in death) I a	inal littlons, teddete littlons st	bd	Due to (ial In or es e cons or es a cons	Equence of): equence of):	on			23b. Dld 1 □	tobacco use co Yss 2⊠No s en eutopsy	ntributs to	Approximate Interval Between Onset and Death on the cause of death bebly 4 unknown dere eutopsy finding
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antificate has been signed by the attending physician and transit augment of the property of the physician and transit and the physician/Medical Examiner	Immediate Cause (Fis disease or condition resulting in death) Sequentially list cond if any, teading to immediate. Enter Underly Cause (Disease or in that initiated events resulting in death) I a	inal dittons, nediete jung jury st	bdontributing to c	Due to (ial In or es e cons or es a cons	Equence of): equence of):	on euse give	en in Pert I		23b. Did 1 □ 24a. Wes	I tobacco use co I Yss 2 ¼ No s en eutopsy ormed?	ntributs to 3 Prol	Approximete Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Death Onset and Death
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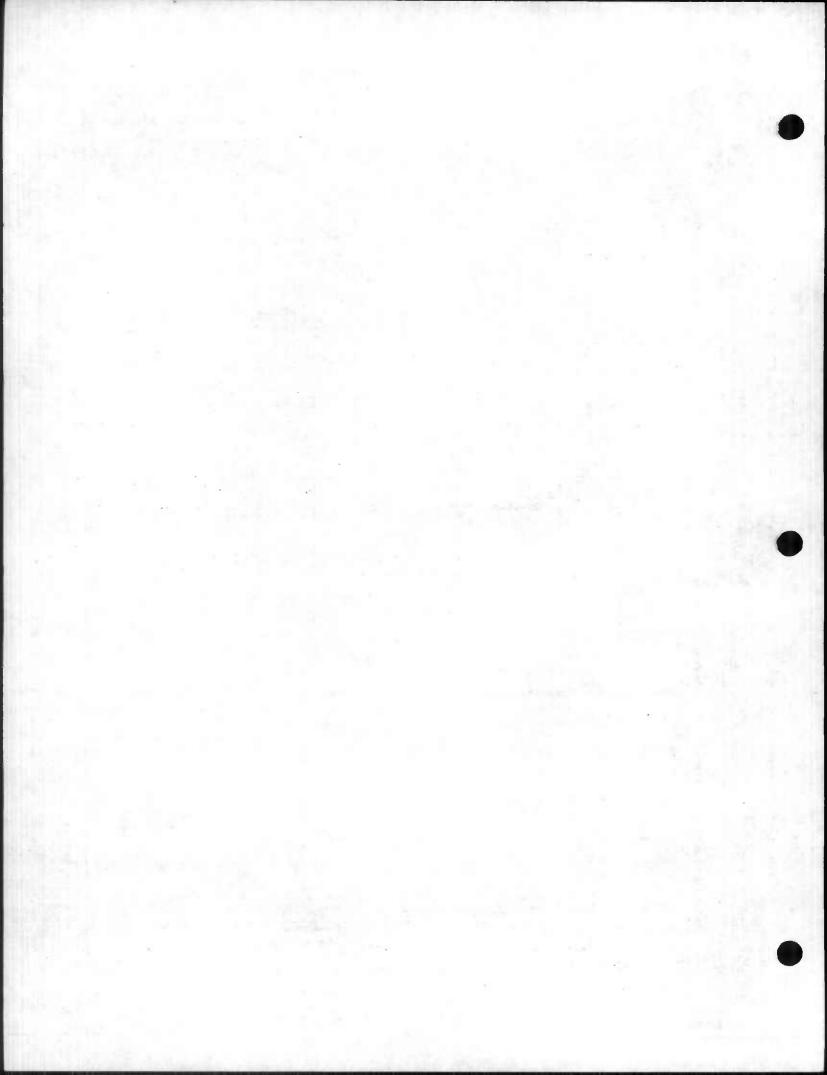
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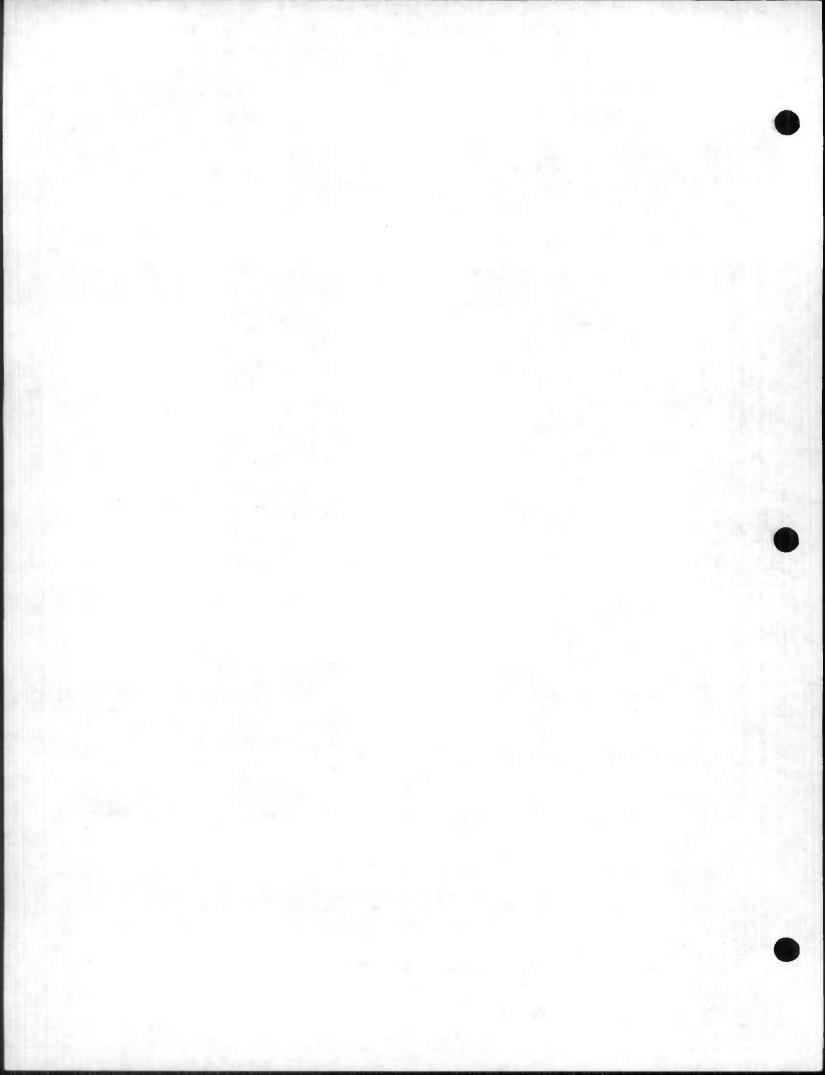
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Examiner	4e Facility Name (If not institution, give	street and number)		- 10/9		4b. City, Town,	or Location of Dea		ounty of Death		
	Bedford Court N	ursing Home				Silver			ontgom		
Funeral Director	217 30 2394	7. Age (// □M 2⊠F 88	yrs. last birtho	Months		If Under 24 H	Irs. 8. Dete of B (Month, D Sept.	irth Pay, Year) 25,191		nplace (State untry) V York	
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or 28s-f is be notified	10e. Street and Number				ip Code	-0		10g. Citizer	of What Cou	untry?	
ES E	3701 Internationa	al Dr.			2	0906		Unit	ed Sta	tes	
Harra Harra Dar m	11. Merital Stetus 1 ☐ Never Married 2 ☐ Merried 3 ☒ Widowed 4 ☐ Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:	r in U,S.			Hispanic Origin? een, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		Race - Amer Bieck, White pecify: W		
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Z1Z15-U od within 72 ho vgiene. wer than "natur it, the Medical. Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	1	fe. DO NOT	use retire	ed)			3 3		
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To Tank	19a. Informent's Neme/Reletionship (7	Updyke	10h A	Aniling Addra	ee (Straa	Elsie	E. Rural Route Num		Diet:		
Maryland 21215-0036 nd 2 should be filed within 72 hours at the and Mental Hyghen. 27 is merked other with Medical Exam r traumatic event, the Medical Exam To Be Completed by F	Don Jenkins / Repr	sonal cesentative					Silver S			0910	
	20e. Method of Disposition		20b. Plece of D				Dete		tion - City or 1		
Saltimore, emit. Pages 1 a opariment of Hes nportant: If Item ny Injury or othe nos.	1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		ake Ci	cemat	ory Inc			tsvill	e, MD	
Depart Inpod	21. Signeture of Funerel Sarvice Licens	Consideration of the second		Step	nen	D. Lohr	d Cremat: mann P.A. Silver S			910	
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cate be associted cate be associated by the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue	to (or as a co	nsequence of):					26	
687 ficate physis the	resulting in death) Lest	Due	to (or es e con	nsequence of):			J-			
the ett the ett ysicis	Pert II. Other significant conditions co	ntributing to death but n	ot resulting in t	he underlying	cause g	iven in Pert I.	23b. Di	d tobacco us	e contribute	to the caus	e of death?
P tat the Person of P	Hypernatremia						10] Yee 2□	No 3□Pr	obably 4	Unknow
requirements of the second should be second should should be second should	4.04						24a. We	es en eutopsy formed?		Were eutops eveilable pric completion of deeth?	or to
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VITAL stelen: The confilent director, pa	25. Wes case referred to medical examiner?						Deeth (Check only	one)			
L 8 55 5	1 ☐ Yes 2 🖾 No		2□ ER/Outp	atient 3 🗆 [JUA		g Home 5□Re	sidenca 6 [Other (Spec	cify)	
	27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Ye	ear) 28b. Tir		28c. Inje Wo	iry et ork?] Yes 2 ☐ No	28d. Describe	e how injury o	occurred		
Division (To the Hospital or Attending P Within 24 hours after deeth. To the Funeral Director: After t completely filled in by the funer Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of Injury building, etc. (5	At home, fam Specify)	n, street, fecto	ory, office		28f. Location City or T	(Street end i own, Stete)	Number or Ru	irel Floute N	umber,
n 24 hours Funer Metely fill		rsician: To the best of m iner: On the basis of exa and menner steted	aminetion and/								e(s)
To th To th comp	29b. Signature and title of certifier	,,	1	2		se number		29d. Date	signed (Month	n, Day, Year)
8	1 /ufa	-10 h	-	ins	0:	13357		11	16/20	200	
O	30. Neme and address of person who o	ompleted cause of deeti	(Item 23a) (T	ype, Print)	- 6			/	1-		
	Lee Jonathan Mush	er, M.D.: 5	530 Wi	sconsi	n Av	e. #104	Chevy	Chase,	MD 2	20815	
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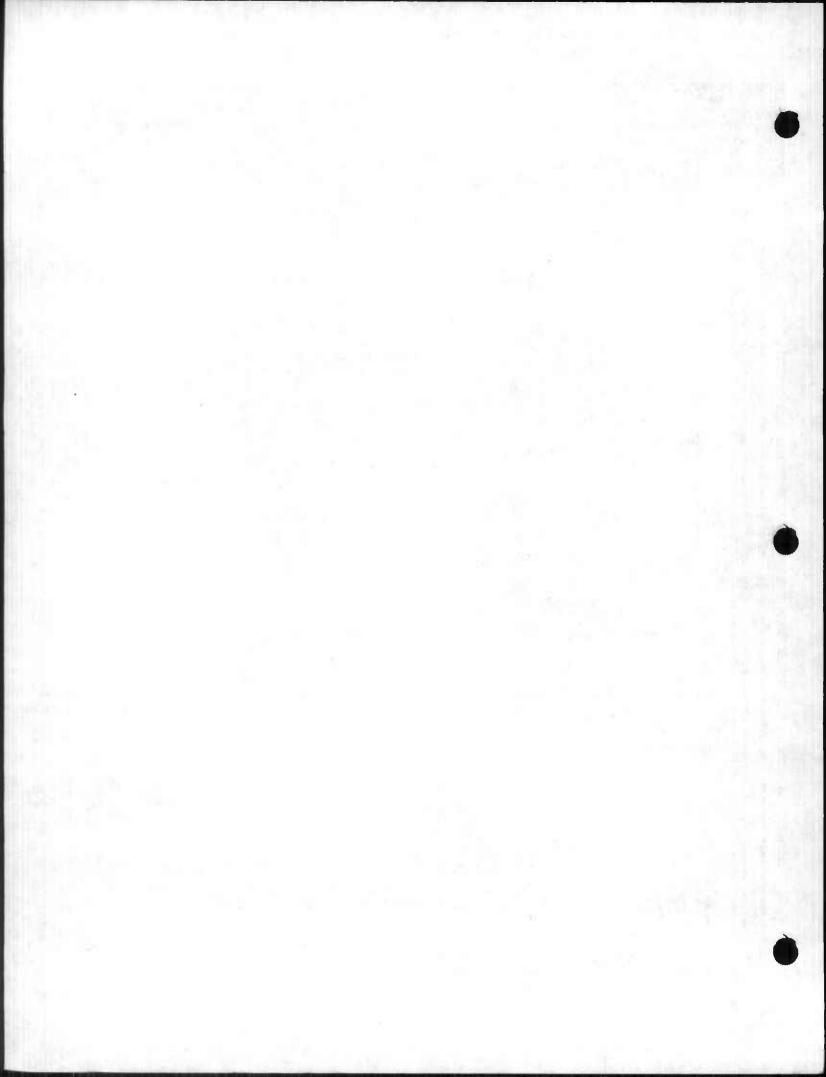
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				Cei	rtificate	e of i	Death			Reg. No.			
	1. Decedent's Neme (First, Midd	fle, Last)							2. Dete of De		Van	3. Time of Death	
Physician	Julia M. Mara								Novem	ber 7, 2	Yeer 000	4:45 pm	
/Medical	4e Facility Neme (If not institution	on, give street end n	um <i>ber</i>)			- 4	4b. City, To	wn, or Lo	ocation of Deel			T 4.45 PIII	-
Examiner	THE CONTRACTOR OF THE CONTRACTOR			Variation of	Comb	- m T	Dunto		11.				
	Holy Cross Reha	6. Sex								Montgo			
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Director	102-18-9839		7	/ 113.					Mar 21	, 1923	New	Jersey	
within 72 hours effer death with the Menyland ane. The natural, or items 23s or 28s-1 show the Medical Examiner result to notified and present the professional professional professional professional professional precedence.	Usuel Residence of Decedent 10a. Stete 10b. Count		100 0	ity, Town or Lo	onting	-						10d. Inside City Limit:	
Department of Heelth and Mertiel Hygiene. Important: If Itam 27 is marked other than "natural", or itema 23a or 28a-1 show any Injury or other traumatic avent, the Medical Examinat must be nothed at once. To Be Completed by Funeral Director	Toa. Stelle	y	100.0	ny, town of Lo	Cation							1 Yes 2 N	
15 0	Virginia Fairf	ax	Fa:	lls Chu	rch							1 Tes 2 LAIN	D
Director	10e. Street end Number				10f. Zip	Code				10g. Citizen of V	What Cour	ntry?	
1 -	809 W. Broad St	treet			220	46				USA			
Funeral	11. Meritel Status	12. Was De	cedent Ever in I	J,S. 13.	1		lispenic Or	igin? (Sp	ecify Yes or N Rican, etc.)			can Indien,	
E.	1 Never Merried 2 Ma	Armed F	20 No			V			Hican, etc.)		ck, White,		
þ	3 ☐ Widowed 4 ☐ Divorce	If Yes. G	Sive		1□ Yes :	2 No	Specify:			Specify	v: Whi	.te	
8	15 Decede	nt's Education		16a Dece	dent's Usue	1 Occup	etion			16b. Kind of Br	usiness/In	dustry	
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Be	17. Father's Neme (First, Middle	, LES()								, Meiden Sumen	10/		
9	Joseph Mara						Madg	e By:	rnes			1000	
	19e. Informent's Neme/Reletion	ship (Type, Print)		19b. Meilir	ng Address	(Street	end Numb	er or Run	al Route Numi	ber, City or Town,	Stete, Zit	Code) 20904	
	Joseph P. Brent	neis / Con	usin	3118	Grac	efie	eld R	oad A	Apt 202	, Silver	r Spr	ing, MD	
	20a. Method of Disposition		20b.	Plece of Dispo	sition (Nen	ne of	an l		Dete	20c. Location -	City or T	own, Stete	
	1 XBurial 2 Cremetion		n State	cemetery, crei		_		1	1/10/00	Clinton	ь МГ		
	4 Donetion 5 Other (Ne	surrec					1/10/00	CITITO	.I, FIL	,	
buce	21. Signature of Funeral Service	Licansee	0 0		2. Name en				Funers	1 Home,	Tnc		
a	(make	WH	ole									ng, MD 209	01
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an		V									1	Onset and Death	
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er	disease or condition resulting in deeth)	a. Caro	diopulmo								-		-
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nin		b. Phet	ımonia								1		
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E	cause. Enter Underlying Ceuse (Diseese or Injury												
Ö	thet initieted events resulting in death) Lest		Due to (or es e conseq	uence of):								
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by Physician	Pert II. Other significant conditi	ione contributing to	deeth but not re	sulting in the u	nderlying c	ause giv	en in Pert	I.	23b. Dic	I tobacco use co	ntribute t	to the cause of death	7
hy									10	Yee 2□ No	3□ Pro	bably Unknow	wn
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ToE	exeminer?	Hospitel:	inpatient 2	☐ ER/Outpatie	nt 3 DC	A Oth	er: 4KIN	ursina Ha	me 5 Res	idenca 6 Oth	er (Speci	(h)	
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io	1 Neturel 5 Pendi	ng (Mo igation	nth, Dey Year)	injury	м		rk? Yes 2□	No					
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Ť	4 Homicide determ	mined 200. Piec	ce of Injury - At I ding, etc. (Spec	nome, term, str ify)	eet, factory	, OTTICE				own, State)	er or Hun	ral Route Number,	
edicai	29a. Certifier 1 Certifyl (Check only 2 Medical	ng Phyelcian: To the Explininer: On the	e best of my kn	owledge, deet	n occurred	et the tir	ne, date er	nd plece,	end due to the	ceuse(s) end me	enner es s	stated.	
Pe	one)		nner stated.	otion and/or in	-ostigation,	, III IIIY O	pinion, det	orn occur	er er trie tillije	, date end place,	and due t	o are ceuse(s)	
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	> V///	/ 1	m. K)	1	Mr	77	2112		11/8	1150)	
	20 1000			00 1	200		200	11)		100	()	
	30. Neme and address of person	who completed cau	use of death (Ite	m 23a) (Type,	Print)	00.	A	-	81	C 1	1	6-bung	,
	F. OS.LIS	C NO RO	110	106	DOL I	100	2110	NN	46	owy	0	MIN	
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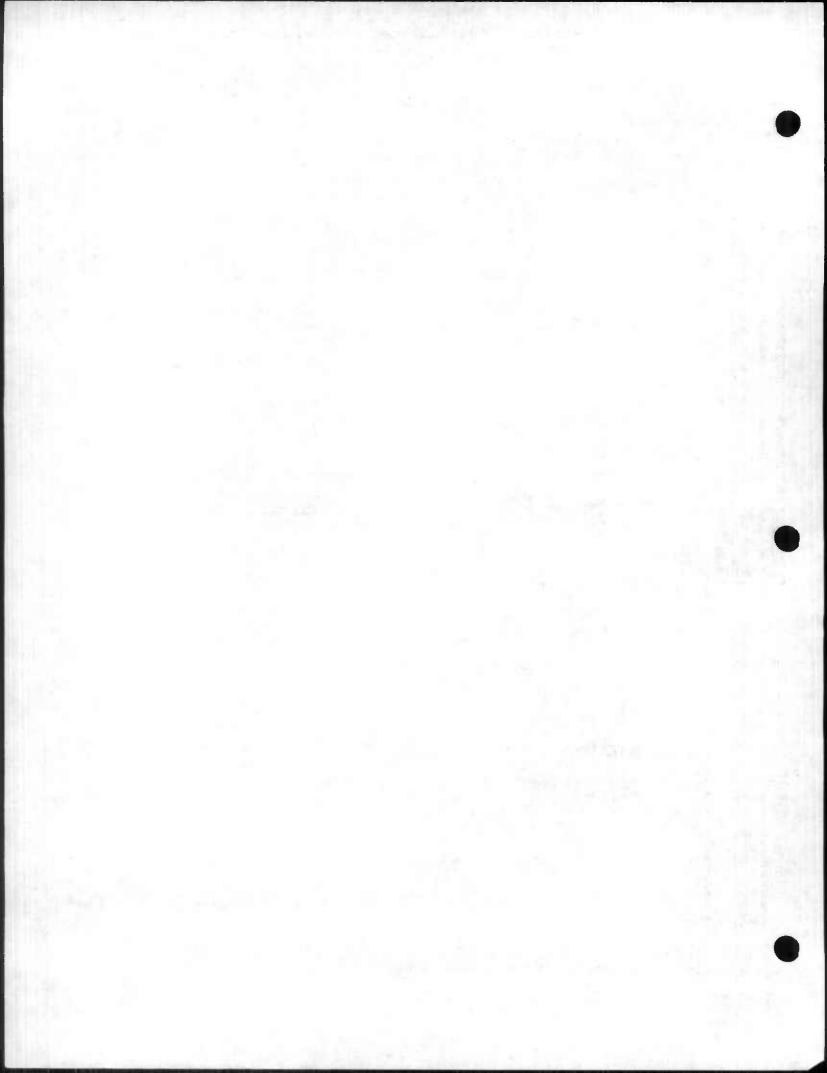
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an al	Mary Pa	auline 1	Marchon	e			1 -	rembe	r 6 20	OO0	9:30	P.M.
	Facility Name (If not institution,	give street and number,				4b. City, Tov	wn, or Locatio	n of Death	4c. County	of Death		
4	409 Woodland Ro	oad					ersburg	3	Montg	omery	r	
5	79-20-4655	6. Sex 7. Ag	ge (In yrs. last b		f Under 1 Year fonths Days		7. 7.	ate of Birth Month, Day	2, 1924	Carin	itry)	te or Foreigi
-	ual Residence of Decedent 1. State 10b. County		10c. City, Tox	wn or Locati	ion		-			1	Od inside	City Limits
	ryland Montgo	mowii	Gaithe									es 2 □ No
_	. Street and Number	шегу	Galtile		10f. Zip Code				10g. Citizen of V	What Cour	itry?	
	409 Woodland Ro	Loc			20877				United S			
-	Marital Status	12. Was Decedent	Ever in U,S.	13. Was	s Decedent of I	Hispanic Orig	gin? (Specify			e - Americ		
	1 Nevar Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces' 1 Yes 2 1 ff Yas, Give Year or Dates:			es, specify Cub		, Puerto Rice	n, etc.)		ok, Whita, www. Wh:		
	15. Decedent'		166	a. Decedent	t's Usual Occu	pation	t of working		16b. Kind of Bu	usiness/Inc	dustry	
E	(Specify only highest Elamentary/Secondary (0-12) 12	College (1-4or		iiie. DO	d of work done NOT use retire iker	during most id)	or working		Own Hom	ne		
17.	Fathar's Name (First, Middla, L	ast)				18. Mothe	r's Name (Fir	st, Middle,	Maidan Sumam	10)		
	Charles Erlen	bach		1000		Mary	Ryan		750.5			
	a. Informant's Name/Ralationsh								r, City or Town,			
T	homas J. March	one, Sr.				Road			irg, Mar	-		
20a	Method of Disposition □ Burial 2		cemet	ery, cremate	on (Nama of ory or other pla an Crem		Nov.		20c. Location - Alexand:			
21.	Signatura of Funeral Service L	LO14							ral Home ersburg		208	77
dis	mediate Causa (Final ease or condition ulting in death)	. Chronic	Dua to (or as a	consequa	nca ot):						2 mo	
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Par		d										
Par	t II. Other significant condition	s contributing to death t	out not resulting	in the unde	ortying ceuse g	ven in Part I.		23b. Did 1	obacco use co	ntribute to	the cau	se of death
	Insulin Depende	ent Diabete	s Melli	tis				10	Yes 2 No	3 Pro	bably 4	I □ Unknov
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								1 🗆 🗅	res 2 No	1[□ Yes 2	2□ No
	Was cese raferrad to medical axaminer?					26. Placa	of Death (Ch	eck only o	na)	-		
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	4 ☐ Homicida determin		ic. (Specify)					City or Tov				
298		Physician: To the best xaminer: On the bests of and manner st	of examination a									se(s)
	o. Signature and title of certifier		^		29c. Licen	se number			29d. Date signe	d (Month,	Day, Yea	(r)
30	Nama and address of person w	no comblete cause of	death (Item 23e	(Type Pri		4157		N	lovember	7,	2000	
	Ira Berger, M.	D. 809 Vei	rs Mill		•	Rock	ville,	Mary	land 20)851		
31.	Date filed (Month, Day, Year)	32 Regist	rar's Signature	9	how Ka							



State of Maryland / Department of Health and Mental Hygiene

						Ce	ertificat	e of	Death			Reg. No.			C/ I
Discort.		1. Decedent'a Name (First, Mide	dle, Last)					010		334	2. Date of Dea	ath Day	Year	3. Time o	f Death
Physic /Med		10%		Marth	a Klei	n McL	eod				Oct.		2000	1:30	P.M
Exam		4a Facility Name (If not institution			ber)						ocation of Deeth				
		9616 E. Bext			A		/) If Unde	r 1 Van		nsin 24 Hrs.	gton		tgome		
Funera Directo		5. Social Security Number 217–46–5935	6. Sex	2 🛭 F	Age (tn yrs. 1	Yrs.	Months	Days		Min.	8. Date of Birt (Month, Da April 2	Year) 1912	Cour	place (State of the state)	
pue M		Usual Residence of Decedent 10a. State 10b. Count	у		10c. City	, Town or 1	ocation	-						IOd. Inside C	City Limits
he Many Ba-f aho	Director		gomer	У			- T		ensing	gton					2 ☑ No
death with the Maryland ms 23s or 28s-f show		10e. Street and Number 9616 E. Bext	hill I	Orive			10f. Zip	Code		2089		10g. Citizen of U	. S.		
or He	by Funeral	11. Marital Status 1 Never Merried 2 Ma 3 X Widowed 4 Divorce	rried	Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date	⊠ No	S. 13	. Was Dece If Yes, spe 1 ☐ Yes				pecify Yes or No Rican, etc.)	Bia	ce - Americk, White, White,		
72 hours	Completed	15. Decede (Specify only high	nt's Educat	ion om <i>pleted</i>)		(Giv	edent's Usu	rk done	durina mos	st of worl	king	16b. Kind of B	lusiness/In	dustry	
within bne.	idm idm	Elementary/Secondery (0-12)		College (1-4		`life.	DO NOT u	se retir	ed)			T 41			
	S	17. Father's Neme (First, Middle	Last)	5 +		LI	brari	an	18. Moth	er's Nam	e (First, Middle,		orary		
d be ontail	o Be	Friedrich Ka		ein							eda Kru				
Maryland of 2 should be filed the and Mental Hyg 7 is marked other traumetic event,) =	19a. informant's Name/Relation				19b. Me	ling Address	s (Stree	at arid Numb		ral Route Numbe		, Stete, Zij	Code)	
C = 01 +		Elizabeth McLe	od -	Daught	er	9616	E. B	exhi	ill Dr	ive	Kensi	ngton,	MD 2	20895	
Poge Ar: F		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (noval from St	oto C	emetery, cr	ek Ce	other pla		1	Date 1/3/00	20c. Location Washin			
Baltim pamit. Pe Department important: eny Injury		21. Signature of Funeral Service	-	0-	10/		22. Name a	nd Addr	ess of Facil		seph Ga Washin			2001	6
		23e. Pert1. Enter the dispese, of shock, or heart fellure. List	5	Kow	Ma	_								Approxima	
X 58 / 50, antificate be executed ling physician and e as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last	b		uere. Due to (or	left ur as a conse	ent.	1	lan e	dys:	accid	ralane	wys	Parties and the same of the sa	
deeth cert deeth cert e attendin ed for use	clan		- 0										1		
. 0 0 0	Physician/	Part II. Other significant condit	ions contril	build to dear	a from	ulting in the	underlying (ceuse g	iven in Part	l.		Yes 22 No	-		
cord requir	Completed by	Hypoth	yro	disi								en autopsy ormed?	a c	ere autopsy vailable prior empletion of death?	to
The law	ome	Prin	Con	olan.	MALL	lan	OPA	2	ent		10	Yes 2 No		Yes 2] No
VITAL I	BeC	25. Was cese referred to medic	ai	00 -00	00400				26. Plac	e of Dea	th (Check only o	one)			
OT VITA Physiclen: rthis certific rral director,	To	exeminer? 1 Yes 2 No				ER/Outpati		UA		ursing H	ome 5 🖾 Resi	dence 6 🗆 O	her (Speci	(ty)	
UNISION OF VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death 1 Neturel 5 Pend 2 Accident inves 3 Suicide 6 Could	tigation	28a. Date of (Month,		28b. Time Injury	М		Yes 2] No		how injury occu			
DIVI	Certifi		mined	28e. Plece o building	f Injury - At ho g, etc. (Specify	ome, ferm, s	street, factor	y, office	•		City or To	Street and Num wn, State)	iber or Hui	ai Houte Nur	m <i>ber</i> ,
To the Hospital within 24 hours a To the Funeral Completely filled	edical				is of examinat						, and due to the rred et the time,				(s)
within 2 To the	Me	29b. Signeture and title of certifi	er	10			29	c. Licer	nse number			29d. Date sign	ed (Month,	Day, Year)	
20		Marte	na 1	Kein	- Mg	5	pl	12	D44	369	7	11/	3/00	0	
		30. Name and address of perso	n who comp	oleted cause	of death (Item	23a) (Type	e, Print)					+			
		Martha E. Ke			50 W.		ston 1	Driv	re #4	03	Rockvil	le, MD	2085	52	
Si Regis	tate trar	31. Date filed (Month, Day, Yea NOV 06		32 Aeg	gistrar's Signa	G.	100	els							

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2000 **Physician** 4:00 AM November ELIZABETH COSTELLOE **METZLER** /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Wilson Health Care Center Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 F 87 Yrs. Director 579-28-7543 Sept. 2, 1913 Iowa Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow 1 ☐ Yes 2 No Director 28a-f Montgomery Gaithersburg 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ŏ U.S.A. 238 301 Russell Avenue 20877 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 14. Race - American Indian. 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Merried à 1 ☐ Yes 2 No Specify: Specify: White PV 3 XWidowed 4 □ Divorced "national" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) 5+ Elementery/Secondary (0-12) Homemaker Own Home 17. Father's Name (First Middle Lest) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fall ment of Health and Mental H ant; if them 27 is marked off Be Martin Costelloe Matilda Wechbaugh 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Robert W. Metzler (Son) 7119 Fairfax Road Bethesda, MD 20814 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 11/10 Silver Spring, MD 22. Name and Address of Facility
JOSEPH GAWLER'S SONS, INC. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave., NW Washington, 20016 DC Athen Muna 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer feilure. Ust only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disaese or condition resulting in death) /Medical week Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es a consequence of): Physician/Medical the Due to (or as a consequence of): 82 950 Jou Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Onknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? certificate has 2 No 1 ☐ Yes 2 ☐ No 1 Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menne of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and II 2000 U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell 91 6 authors burg even olinsk

30

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72 hours after

filed within

The lew requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

or Attending Physician:

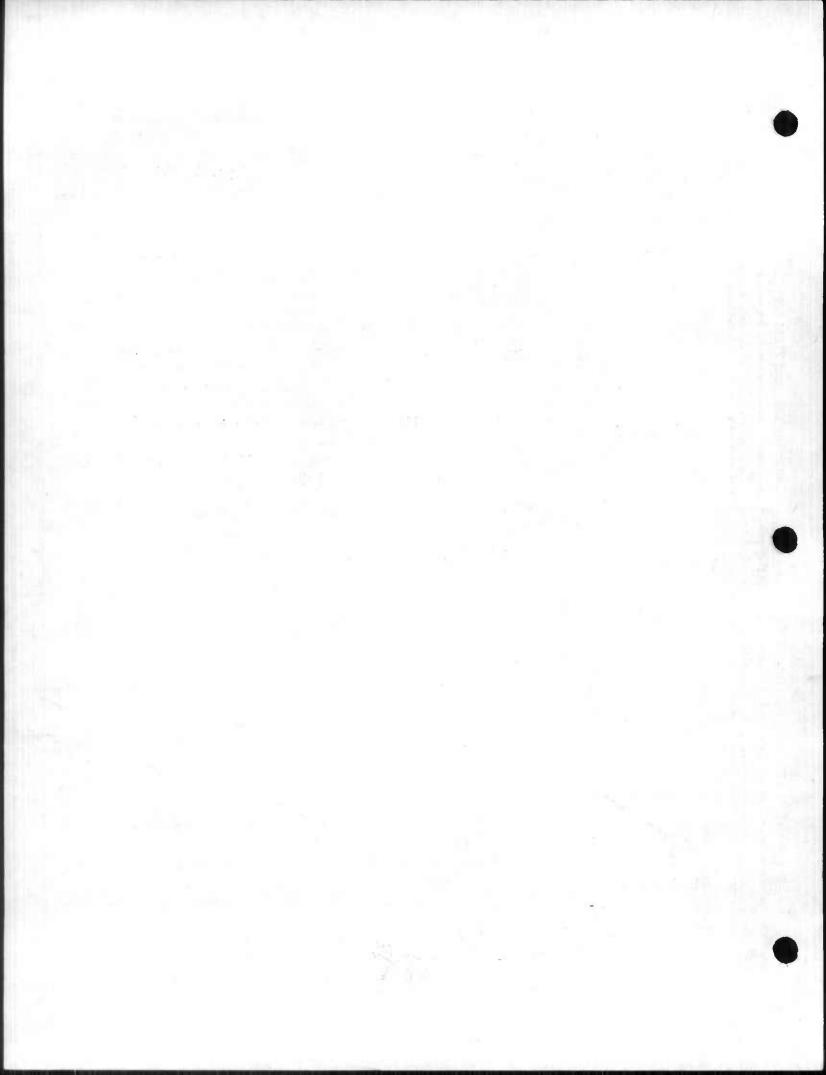
Baltimore, Maryland 21215-0020

State Registrar 31. Date filed (Month, Day, Year)

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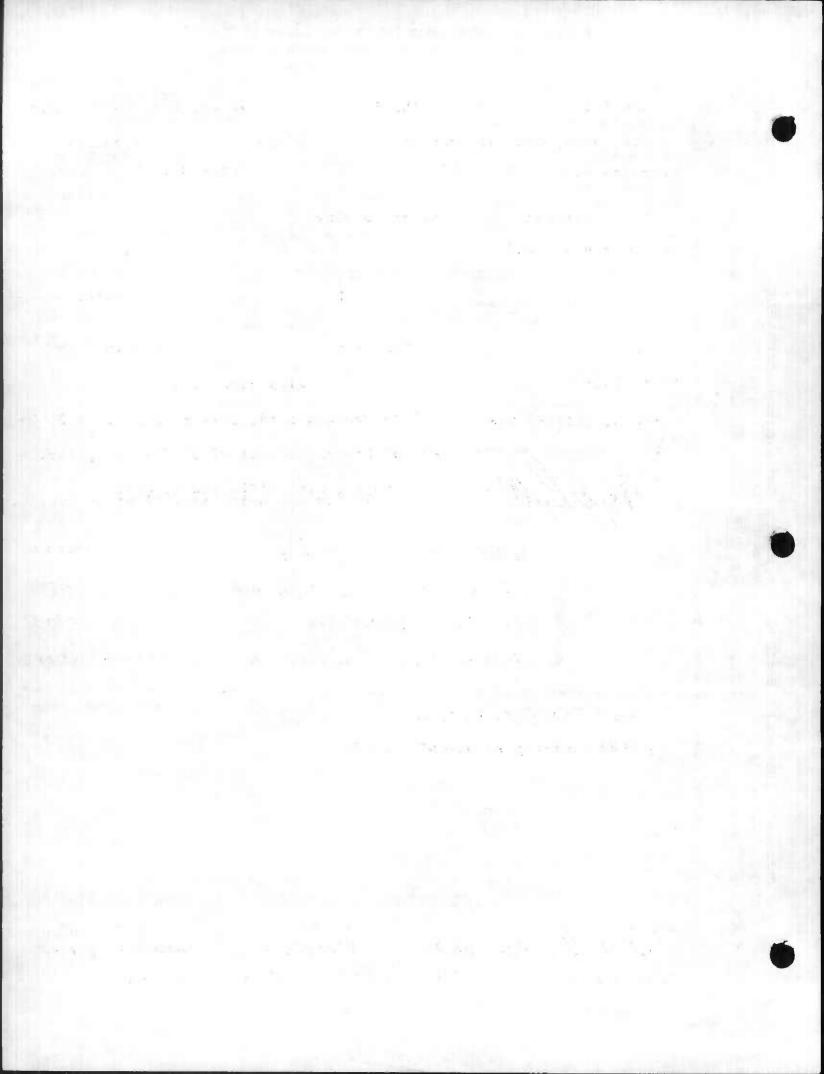
32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate	e of L	Death			Reg. No.			
	1. Decedent's Nan	na (First, Middla, La	ist)							2. Data of De		Maran	3. Time of De	ath
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/Medical Examiner	4e Fecility Nama	(If not institution, giv	va street and number				4	b. City, To	wn, or L	ocation of Dee		y of Death	0,000	A 413
	Mont	tgomerv	General	Hospi	ta1			01r	1ev		Mo	ntgom	lorv	
Funeral	5. Social Sacurity I			ge (In yrs. last		If Undar		If Under	24 Hrs.	8. Data of Bi	rth	9. Birthp	lace (Stata or Fo	oraign
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with the Marylend to or 28a-f show the notified at	10e. Street and Nu		D I			10f. Zip					10g. Citizan of		try?	
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ifier death with the Mar r ferms 23s or 28s-1 si finer must be notified Funeral Director	11. Marital Status		12. Was Decedan Armed Forcas	t Evar in U,S.	13. V	Ves Deced Yes, spec	ant of Hi	spanic Or n, Maxicai	igin? (Sp n, Puarto	ecify Yes or No Rican, atc.)		ce - Amarica eck, White, a		
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that the death certificate of by the attending physicatched for use as the Physician/Medic														
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ed by datac	URINA	RY TRA	ET INF	ECTIO.	N					1	Yes 22 No	3 Prot	bably 4□Un	Know
The law requires that the death of the law requires that the death of page 2 should be datached for us.			CT INF							24a Wa	s an autopsy	24b. W	are autopsy find	lings
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The law requires the law requires the last been signed paged 2 should be completed by													death?	
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H Sign	1 Yes 2 E		1 🗆 Inpai		Outpatien			4U N	ursing He		idence 6 🗆 O		y)	
tal or Attending Pins of the dash. al Director: After the din by the funara Certification:	27. Manner of Dea	5 Panding	28a. Data of In (Month, D	ay Year)	b. Tima of Injury		8c. Injun			280. Dascribe	how Injury occu	Irrea		
To Attending Physicien: The effer death. Director: Affer this certificate director, partification: To Be CC ertification: To Be CC	2 ☐ Accidant 3 ☐ Sulcida	Invastigatio	0			М		Yas 2□	No	mos harastian	(04	haras Dom	I Davida Alivada	
trect in by	4 ☐ Homicida	determined	286. Place of II	njury - At homa atc. <i>(Specify)</i>	, farm, str	aat, factory	, office				(Straat and Num own, Stata)	iber or Hura	.i Houta Numba	r _e
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To the Hospital or Attention within 24 hours efter death of the Funeral Director: complately filled in by the Medical Certifical		d title of contilien	and manner s	stated.		200	Licene	e number			29d. Data sign	ed (Month	Day, Year	
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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hysician				Cei	rtificate of	Death		Reg. No.		0.51 (5.4)
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/Medical	Magalino Ang						Octo		2000	902 am
caminer	4a Facility Name (If not institution		ber)				r Location of Dea	th 4c. Count	y of Death	
	7309 Second Av					Sykesvi			roll	
eral tor	5. Social Security Number 578-84-0776	6. Sex 1 AM 2 F	7. Age (In yrs. la. 65	st birthday) Yrs.	Months Days		n. (Month, D	rth ey, Year) .2, 1935	9. Birthp Coun Wash:	lace (State or Foreign try) ington, D.
	Usual Residence of Decedent		1.0.00							
rector	10a. State 10b. County			Town or Lo					1	0d. Inside City Limits
cto	Maryland Carr	oll	Syk	esvil	le					Y☐ Yes 2☐ No
al Dire	10e. Street and Number 7309 Second Av	enue			10f. Zip Code			10g. Citizen of United		
by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	Armed For	2XXV0		Was Decedent of I If Yes, specify Cub 1 XYes 2 No			Bla	ca - Americack, White,	
P		of's Education		16a. Dece	dent's Usual Occup	pation	orkina	16b. Kind of E	Business/Inc	dustry
Be Completed	Elementery/Secondary (0-12)	cst grade completed) College (1-	4or 5+)	life.	kind of work done DO NOT use retire	ed)	Oiking	None		
Ö	17. Father's Name (First, Middle,	(act)		11011		18 Mother's N	ame (First, Middle		me)	
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23a. Part 1. Enter the disease, shock, or heart failure. Use the shock of the shock	a b A c d one contributing to decome	SPIT Due to (or e	as a consecution of the united states of the united	tion (source of):	OF A W	1 th	d b Sen	3 Prod	Approximate Interval Between Onset and Death Death Onset and Death Death Onset and Death	
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Medical Certification: To Be Completed	3 Suicide 6 Could determ	not be nined 28e. Placa buildin	of Injury - At hong, etc. (Specify)	Ho	reet, factory, office		Subjection Sylvin	es vil	ked hoer or Auro le, M	on Food of Route Number, Naryland
9	29a. Certifier 1 Certifying (Check only 2 X Medical	ng Physician: To the t Examiner: On the ba and mann	sls of examination	on and/or in	n occurred at the t vestigation, in my	opinion, death oc	ca, and due to the curred at the time	e cause(s) and n), date and place	nanner as s , and due to	taled.
Medical Certificatio	one)									
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #1 11/13/2000, BMW, Montg. Co. Certificate of Death 1. Decedent's Neme (First, Middle, Last) Neuhause 2. Dete of Deeth 3 Time of Death **Physician** Ear Edna 55C NOV 5000 /Medical 4a. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death NEG ere VEL somer 8. Data of Birth (Month, Dey, If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** Deys 1 M 2 F Months Hours 579-48-9929 89 **Director** JULY 16, 1911 TEXAS Usuel Residence of Decedent deeth with the Maryland 10a. State 10b. County Show 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f showing Western Examiner must be notified at Director 1X Yas 2 No MONTGOMERY SILVER SPRING 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2107 BELVEDERE BLVD. 20902 Funeral U.S.A. 12. Wes Decedant Evar in U,S. Armed Forcas? Wes Dacedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Bleck, Whita, atc. Pages 1 and 2 should be filed within 72 hours aftar 1 Yas 27 No If Yes, Give 1 Nevar Married 2 Married 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 ☐ Divorced Yaar or Detes WHITE Completed 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry al Hygiene. SCHOOL Elementery/Secondery (0-12) College (1-4or 5+) SIDWELL FRIENDS PUBLIC RELATIONS DIRECTOR Maryland 17. Fether'e Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be nt of Heeith and Mental 2 MATTHEW T. BERNIE traumatic WALLING KILPATRICK 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MARY HELEN CANUTO/DAUGHTER AS ITEM #10 SAME other Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Neme of Dete 20c. Location - City or Town, Stata cemetery, crematory or other piece) 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from Stete 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Depertment of Important: If any injury or once. CHAMBERS CREMATORY 11/7/00 RIVERDALE, MD. 21. Signatura of Funeral Service Ligensaa 22. Name end Addrass of Facility 20906 MOCOO91 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD 23a. Part1. Enter tha disease, or complications that caused the deeth. Do not enter tha mode of dying, such es cerdiac or raspiratory arrast, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting In deeth) **Examiner** Due to (or es e consequence of): Examiner The law requires that the deeth certificate be executed usa es the burial-transit Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting In deeth) Lest pue Due to (or es e consequence of): Box 68760 ettending physician for usa es the buria Physician/Medical Due to (or as e consequence of) P.O. been signed by the should be deteched Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? complation of cause has 1 ☐ Yas 2 ☐ No this certificate 1 Yes Attending Physician: director Be 25. Wes cese referred to medical 26. Piece of Deeth (Check only one) examiner? Other: 4 Nursing Home Certification: To 1 inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) filled in by tha funeral 27. Menner of Death 28a. Date of fnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After Naturei 5 Pending daeth. 1 Yes 2 No investigetion 2 Accident or Attendation of the date of 6 Could not be determined 3 Suicide 28e. Plece of fnjury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 I Homicide To the Hospital o within 24 hours af To the Funeral Di complately filled ii Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end manner es steted.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to tha ceuse(s) end menner steted. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signatura and title of certifier 29d. Data signed (Month, Day, Year) - mDmE 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BRECHER, MO DME 20902 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signetura State 68 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** November 2, 2000 Gloria May Newnam 8:10 p.m. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth 3579 Chesapeake Villa Apt. 206 Rock Hall Kent Hours Min. 8. Date of Birth (Month, Dey Year) May 4, 1935 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** 1□M XXF Months Deys 65 222-24-9798 Delaware **Director** Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Maryland XXYes 2 No Director Kent Rock Hall 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3579 Chesapeake Villa, Apt. 206 21661 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Americen Indien, Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours effer c Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natures" any injury or other traumatic events. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White by 3 X Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12 College (1-4or 5+) Line Inspector Clothing 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Howard Thomas Pearce 2 Ethel Jessie Poore 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Valerie Lee Donovan 6191 Dorlon Drive, Rock Hall, Maryland 21661 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center, IIIC 11/7/2000 Stevensville, Maryland 22. Neme end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 Approximete Onset end Deeth Physician Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical CARDIO Pulmoriary PRESENT Examiner Legocardial Tufarction or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Box 68760, ettending physician for use as the hund Physician/Medical Due to (or es e consequence of): Division of Vital Records, P.O. Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobecco uee contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown Pulmonany Cultalus g Completed 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy completion of cause of deeth? Dage 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Wes cese referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this 28b. Time of Injury 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Naturel 5 Pending ours efter death. eral Director: Affilled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) and manner as steted.
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32. Registrers Signeture
A 30 Hame end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) John C. ARRABAL JA. M. D 31. Dete filed (Month, Day, Yeer)

DHMH 16 Rev 6/95

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month **Physician** Joseph T. O'Brien November 3, 2000 11:50 pm /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 3330 North Leisure World Blvd., #222 Silver Spring Montgomery | If Undar 1 Yaer | If Under 24 Hrs. | 8. Deta of Birth (Month, Day, Mar 28, Birthplaca (Stata or Foreign DC Country) 5. Sociel Security Number 6. Sax 1 → M 2 □ F 7. Aga (In yrs. last birthday) **Funeral** 75 Yrs 721-01-9422 Director Usual Rasidence of Dacedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23e or 28e-f show the Medical Examiner must be notified at 1 TYas 2 NO Directo Maryland Silver Spring Montgomery 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 20906 3330 North Leisure World Blvd, #222 USA Funeral 12. Was Dacedant Evar in U.S. Armed Forcas? 1 XYas 2 □ No 1943 – If Yas, Giva Was Decedant of Hispanic Origin? (Specity Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Bleck, White, etc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify White Specify: à 3 Widowed 4 Divorced Yaar or Datas: 1946 Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Metropolitan Elemantary/Secondary (0-12) Collega (1-4or 5+) Police Officer 12 Police Department 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) h and Mental I Thomas A. O'Brien Pages 1 and 2 should nent of Health and Man Ellen C. Magruder 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Health important: If Issm 27 I any injury or other tra 9008. Thomas P. O'Brien / Son 6040 Token Forest Drive, Manassas, VA 20112-8800 20b. Placa of Disposition (Nama of cemetary, crematory or othar placa) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata Quantico National Cemetery2000 Quantico , VA 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licensee Francis definitions Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that causad the deeth. Do not anter the mode of dying, such es cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Causa (Final disaasa or condition rasulting in daath)

Physician /Medical Examiner

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with the Maryli

filed within 72 hours after

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Maryland

Baltimore,

Examiner buriel-tran pue ettending physicien

29b. Signature and title of de

31. Data filed (Month, Day, Year)

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| Madical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29d. Data signed (Month, Day, Year)

of Vital Records. After this certificate has director, uneral I or Attending Patter death. Division filled in by the fu Hospital 24 hours a To the Hospital within 24 hours a To the Funeral Completely filled

The law requires that the death certificate be executed

Box 68760.

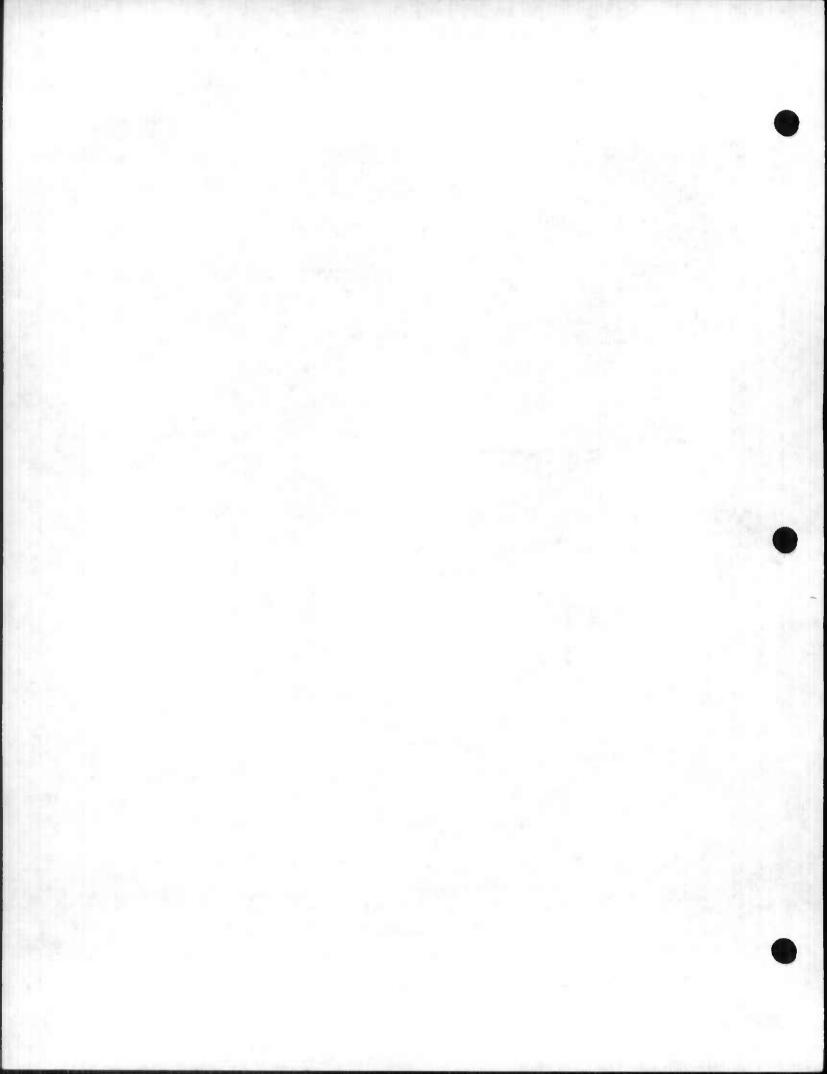
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State Registra

30. Name and address of person who complated causa of death (Item 23a) (Type, Print) 32 Ragistrar's Signatura

29c. Licansa number

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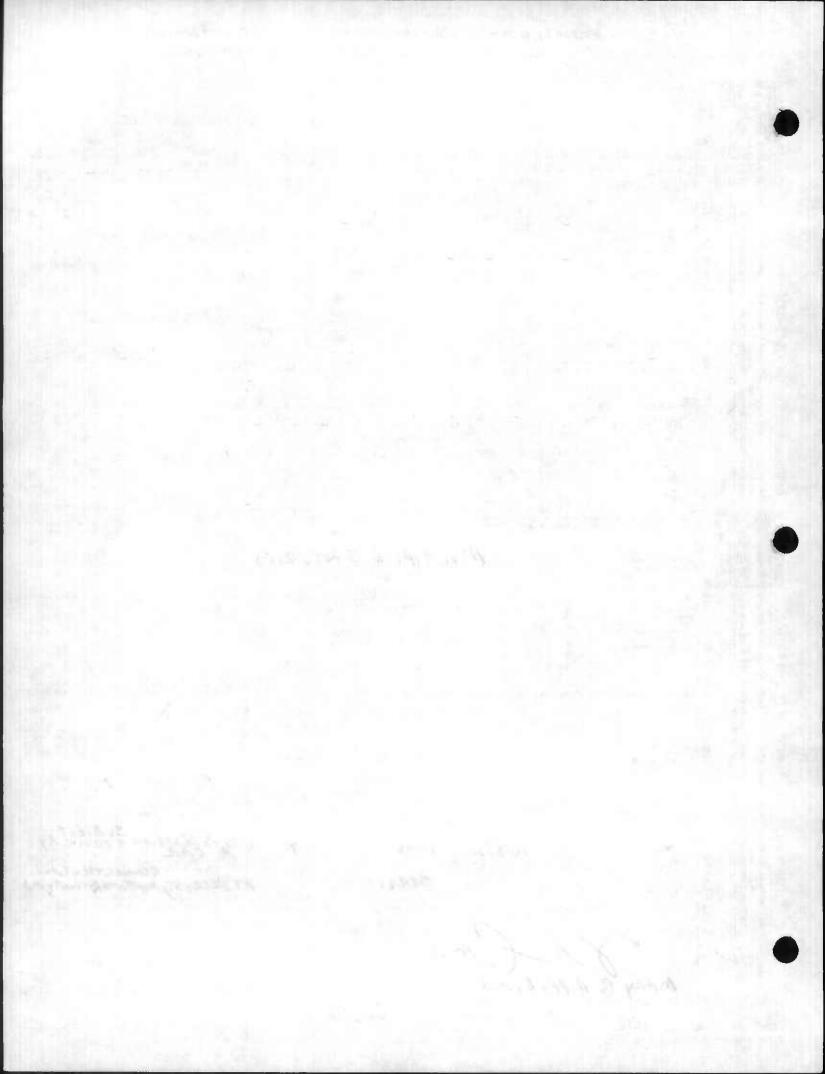


Herman Davis Orange

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 37 60

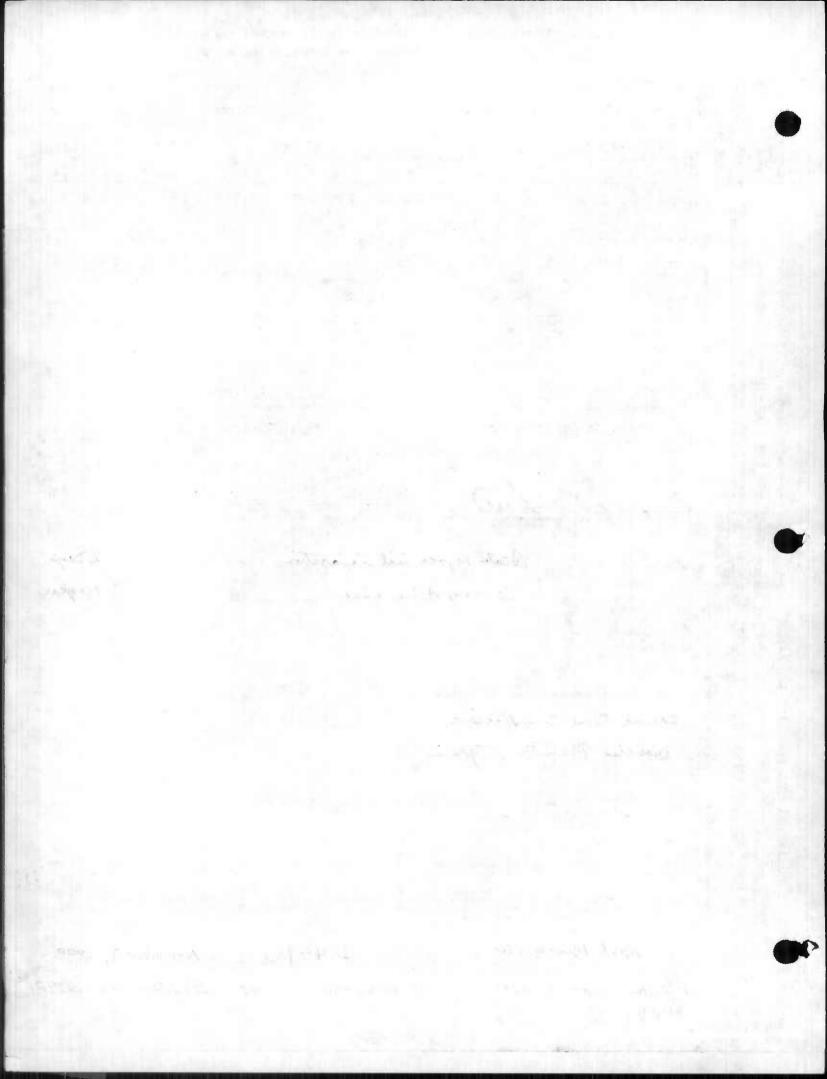
			C	ertificate o	f Death		Reg. No.		
Physician /Medical	Decedent's Name (First, Middla, HERMA		ORANGE			2. Data of De Month Octobe	er 31 2	Yaar 2000	3. Time of Death 08:10 P.M.
Examiner	4a Facility Nama (If not institution, Subu	giva street and number, irban Hospi			4b. City, Town, or Beth			of Death ontgo	mery
Funeral Director	217-42-7879	3. Sax 7. A 1 □XM 2 □ F	ga (In yrs. last birtho	Months Day		. (Month, De	th ly, Year) 28,194		lace (Stata or Foreign try) aryland
f show led at	Usuai Rasidence of Decedant 10a. Stata 10b. County MD Mont	gomery	10c. City, Town o	r Location ensingto	on.			1	0d. inside City Limits
be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V		try?
r, or items 23s or 28s-f shor zarxiosr mast be notified at by Funeral Director	10761 Shaft 11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decadant Armed Forcas	Ever in U,S.	3. Was Decedent o	f Hispanic Origin? (Suban, Maxican, Puar	Specify Yas or No rto Rican, atc.))- 14. Raci	e - Americ k, Whita,	
t, the Medical E.	15. Decedant's (Specity only highest Elamantary/Secondary (0-12) 6th	Education	(0	ecedant's Usual Occ liva kind of work dor a. DO NOT use reti Labore:	na during most of wo red)	orking	16b. Kind of Bu		on Dept.
To Be C	17. Fathar's Nama (First, Middla, La Reuben Orang				18. Mothar's Na	nme (First, Middle ICILLE I	, Maiden Sumam		
0	19a. Informant's Name/Ralationshi Joyce H. Johr			alling Addrass (Stree 238 Firs					
ary or one	20a. Mathod of Disposition 1		cematary,	sposition (Nama of crematory or other p morial (1/6/00	20c. Location - Sandy		
eny inj	21. Signature of Funeral Service L	- Anoi	vden	SNOWDI	Irass of Facility EN FUNER Wash.	RAL HOMI	E, P.A.	e, l	MD 20850
for use as the burisl-transit and claryMedical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	ab b d	Due to (or as a conductor of the conductor) Due to (or as a conductor)	sequence of):	NJURIE	<i>S</i>			
igned by the attendin be detached for usa by Physician/N	Part II. Other significant condition	s contributing to death	but not rasulting in t	a undarlying causa	given in Part I.		Yes 2 No		the cause of death? bably 4 Unknown
should				50.1			an autopsy ormed?	av	ara autopsy findings ailable prior to implation of cause death?
Be	25. Was case referred to medical axaminar?	Hospital:			26. Place of De	aath (Check only	Yes 2 No)	©Yes 2□ No
in by the funeral di ertification: To	1 Yas 2 No 27. Mannar of Death 1 Natural 5 Panding 2 Accident invastige 3 Suicida 6 Could no 4 Homicida	28a. Date of Inj (Month, D	ury 28b. Tim Inju 20 19 19 19 19 19 19 19 19 19 19 19 19 19	a of ry M 1 , straat, factory, office	ijury at Vork?	281. Location City or To	how injury occur DESTRIA CAR (Straat and Numb iwn, Stata) CO	red SU H S7 Der or Rure WNEC	BJECT PANCE BY al Route Number, TTCJTAVE.
To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best caminer: On the basis of and mannar s	of my knowledge, of axamination and/o	PEET eath occurred at the r invastigation, in m	tima, data and piac y opinion, death occ	ce, and dua to tha	causa(s) and me	annar as s	stated. o the cause(s)
dwo V	29b. Signatura and title of certifier	1	MID,		onsa number		29d. Data signe Nover		Day, Year) 1, 2000
		opie, m.s.	111 P	pe, Print) enn Stree	t, Baltim	ore, Mar	yland 21	L201	
State Registrar	NOV 06 2		rar's Signatura	ports	,				



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	Decedent's Neme (First, Middla, Last)		00	ertificate of	2. Dete of Death 3. Time								
Physician	AVERY GWYNN Penni	ngton. Sr				Month Novemb	Year 2000 1435 P						
/Medical	An English Name (If not institution also				4b. City, Town, or								
Examiner	Union Hospital			V9	Elkton		Ceci	7					
Funeral	5. Social Security Number 6. Sec	7. Age (I	n yrs. last birthda	If Undar 1 Yee	r if Under 24 Hrs			Birthplece (State or Foreign Country)					
Director	243-28-7559 Usual Rasidence of Decedent	M 2□F 75	Yrs.	Months Days	Hours Min			North Carolina					
/land	10a. State 10b. County	10	c. City, Town or	.ocation	357			10d. Inside City Limits					
Men H	Maryland Cecil		Elkton					1 ☐ Yas 2 No					
vith the Mer t or 28s-f s be negative	10e. Street and Number		23.71.0011	10f. Zip Coda			10g. Citizen of \	What Country?					
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offer death volumers 234	11. Marital Status	12. Was Decedent Eva Armed Forcas?	r in U,S. 13	. Was Decedant of If Yes, specify Cul	Hispanic Origin? (Specify Yas or Norto Rican, atc.)	- 14. Rac	ce - Americen Indien, ck, Whita, atc.					
by Wh	3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yas, Giva Year or Detes:		1□ Yas 2⊠ No			Specify						
2 ho	15. Decedent's Edu (Specify only highest grade		16a. Dec	edent's Usuel Occu	petion	ndring	16b. Kind of B	usinass/Industry					
ING 21215-Upoe filed within 72 ho tal Hygiene. I other then "neturn event, the Medical Be Completed	Elementary/Secondary (0-12)	Collega (1-4or 5+)		a kind of work done DO NOT use retire	ed)	Jiking							
d 212 filed with Hygiene ther the	10		Sal	esman				oile Retail					
Be file	17. Father's Nama (First, Middla, Last)					ıma (First, Middle	, Meiden Suman	na)					
should the market umatics						Gilley							
Mar 12 sh 16 m 16 m	19a. Informant's Name/Ralationship (Ty		19b. Ma	ling Addrass (Stree	et end Number or F	Ru <i>ral Rou</i> ta Numb	er, City or Town,	Stata, Zip Coda)					
e, R land feelth m 27 mer tr	Audrey M. Graham/			Appleton osition (Nama of	Road, El	kton, Ma		21921 City or Town, Stete					
Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Heelih end Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, that word.	20e. Mathod of Disposition 1 Description 1 Description 2 Description 2 Description 3		cematary, cr Gilpin I Park	ametory or other pla Manor Mem	orial			Maryland					
Balti Permit. Departminiportu any inju	21. Signature of Funeral Service Licente	00 /		22. Nama and Addr	rass of Facility								
n asesa	robby for	Elizar)	1	icks Home	ckton Str	eet, Elki	on, Mary	yland 21921					
	23a Fartt Enter the disease or comple shock, or heart failure. List only or	union has ceused the	death. Do not e	ntar tha moda of dy	Ing, such as cerdia	ac or raspiretory a	rrast,	Approximele Intarval Batwaan					
Physician	Shock, or heart failura. List only one cause on aach line.												
/Medical	Immediata Cause (Final diseasa or condition	Acute 2	huncal	il Talla	oction.			2 Days					
Examiner	rasulting in death)	A Cute)	a to (or es a cons	equance of):	00000	7		10 years					
P # 5		Corona	us Arter	y Diser				10 years					
Boute and -Irens	Sequentially list conditions, if any, leading to immediate	Du	do (or as a cons	equence of):									
68 / 60, icate be executed physician end s the bunal-trensit	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Dua to (or as a consequence of):												
ficate be every physician is the buna													
I HECORDS, P.O. BOX 68/60, The law requires that the death certificate be executed at a has been signed by the attending physician end page 2 should be detached for use as the burial-trensit completed by Physician/Medical Examil													
BOX attending for use						1 100							
CONGS, P.O. BOX (requires that the death certif been signed by the attending should be detached for use as leted by Physician/Me	Part II. Other significant conditions con			undarlying ceusa g	iven in Part I.			ontribute to the cause of death?					
deta deta	Chronic Repal I	muffic les	cy			. 1	Yes 2 No	3 Probably 4 Unknown					
dS, uires th signer ild be d		•	0		24e. Wes en eutopsy 24b. Wara autopsy fit								
v req shou	Diobetes Mell	utus, Ty	re 2			perl	ormed?	available prior to completion of ceuse of death?					
VITAL MECORDS, Ician: The law requires th certificate has been signe rector, page 2 should be BE Completed by		/				10	Yas 212 No	1 ☐ Yes 2 ☐ No					
					26 Place of D	aath (Chack only	- No.	12 163 22 110					
		lospital:	2 ER/Outpali	eni 3 DOA O	thar:	Homa 5□ Ras		ner (Snecify)					
Physic rethis c and dire		28a. Data of Injury	28b. Time	of 28c. Inj		_	how injury occur						
ding ding to	1 Natural 5 Pending invastigation	(Month, Day Yo	ear) Injury		ork? ☐ Yes 2 ☐ No								
To the Hospital or Attending Physwithin 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral of Medical Certification: To	3 Suicide 6 Could not be detarmined	28a. Plece of Injury building, atc. (5	- At home, farm, s Specify)	streat, fectory, office	9		(Street and Num. own, Stata)	ber or Rural Routa Number,					
To the Hospital of within 24 hours at To the Funeral D completely filled i	29e. Certifier (Check only 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.												
the H thin 24 mplete		and menner stated	1.			1							
or or or or	200. Digitatora and this or contino	MA		29c. Licar	nsa number			ed (Month, Day, Year)					
	Monte Males	no, 190		D	44783		Noremb	er 8, 2000					
12,	30. Nama and addrass of person who co	implated ceusa of daat	h (Item 23a) (Typ	e, Print)	1 -1			1 110					
1~	Monte Makous	MD	111_	West HI	gh Stre	et c	= LKTON	U MD 21921					
State Registrar	31. Date filed (Month, Day, Year) NOV 0 9 2000	32. Registrar's	Signatura										
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DHMH 16 Rev 6/95			100	- Color									

ORIGINAL



					Ce	ertificate	e or L	Jeath			Reg. No.		- 15	
sician	1. Decedent'a Name (First, Mid	dle, Last)								2. Date of De Month	Day	Year	3. Time	
edical	Robert O. Pot	:e								October	30	2000	14	15
miner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo													
_	PENINSULA					1	1 Vaar	SAL.	ISBU		WICOM		101-1-	
ral	5. Social Security Number 222-03-8904	6. Sex 1 ☑ M		7. Age (In yrs 80	Yrs.	Months	Days	Hours	Min.	8. Date of Birl (Month, Da	y, Year)	Coun		or Fore
tor	Usual Residence of Decedent			00						Sept 1,	1920	Mary	land	
	10a. Stete 10b. Coun	ty		10c. C	ity, Town or L	ocation		1-11				10	Od. Inside (ity Lim
v Itama 23a or 28a Wher must be not Funeral Direc	Maryland Wicon	nico		De1	mar								1X Ye	2 🗆
	10e. Street and Number		110			10f. Zip	Code	13.44			10g. Citizen of What Country?			
	600 S. Second	Street				218	75				USA			
	11. Maritel Status	11. Maritel Status 12. Was Decedent Ever in U.S. 13. Wes Decedent of Hispenic Origin? (Sp						in? (Spe	cify Yes or No	ify Yes or No-				
	1 Never Married 2 Ma	1 Never Married 2 Married 132 Yes 2 No						1 00110 1	Rican, etc.) Black, White, etc. Specify: White					
d by	3 ₩idowed 4 Divorce	ed i	Yeer or De	etes:1942	-45			Optoy.						4
Completed	15. Decede (Specify only high	ent's Education	on mpleted)		(Give	edent's Usua e kind of work	k done a	during most	of working	ing 16b. Kind of Business/Industry				
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	17. Father's Name (First, Middle	12 Owner & Operator						r's Nama	(First Middle	Maiden Suman				
o Be	Mitchell Monro									Blizzar		,		
7	19a. Informant's Name/Relation				19h Mail	ling Address	(Street s	and Number	r or Rura	l Route Numb	er, City or Town,	State Zin	Code)	+
	George Edward			Frien		. Box					940	Otale, Zip	0000)	
	20a. Method of Disposition	Glay,	21.	20b	Plece of Disp	osition (Nam	ne of		ici ,	Date	20c. Location -	City or To	wn, State	
	Burial 2 Cremetion		ovel from S	Stete	. Stepl				1.1	/3/200	0 Delm	ar. D	E	
all .	4 Donation 5 Other			A St					1	1737200	O DCIM	ar, b	П	-
DUCI	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Short Funeral Home													
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al er	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting In death)	st only one ca	ause on ea	rdio	ith. Do not en	uona	e of dying	g, such as c	cardiac o	respiratory a	rest,	19940	Approxima Interval Be Onset and	twee
ical Examiner	shock, or heart failure. Li Immediate Cause (Final disease or condition	st only one ca	Co.	Due to (th. Do not en	equence of):	e of dying	g, such as c	cardiac o	r respiratory a	rest,	19940	Approxima Interval Be	twee
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Registrar DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

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Decedent's Name <i>(First, Middle, La</i> CHARLOTTE	eet)							Reg. No.			
CHARLOTTE	131)						2. Dete of De		Year	3. Time of Dea	
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	SYMONDS		PITTIN	GER			Nov.	1,2000		9:50PM	
Facility Name (If not institution, give	ve street end numbe	or)				4b. City, Town, o	r Location of Deet	h 4c. County	of Death		
alisbury Center;	Genesis	Elder	Care			Salisbu		Wico	mico		
15-10-6459	Sex 7.7 1□ M 2∑ F	Age (In yrs. 82	lest birthdey) Yrs.	If Under Months		If Under 24 Hi Hours Min	n. (Month, De	rth ey, Year) , 1918	9. Birthp Coun MAR	lece (State or Fol try) YLAND	
ual Residenca of Decedent  n. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Li	
	10									1 ☐ Yes 2X	
ARYLAND WICOMIC	0		SALIS		p Code			10g. Citizen of V	What Coun	Mn/2	
				101. 2		0.01					
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1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Force  1  Yes 2  If Yes, Give  Year or Deter	s? ] No		If Yes, sp			(Specify Yes or No arto Rican, etc.)	Black, White, etc.  Specify: WHITE		etc.	
15. Decedent's E (Specify only highest gri			16a. Deced	dent's Us	al Occup	pation	16b. Kind of Business/Indust			dustry	
Elementary/Secondery (0-12)	College (1-40	or 5+)	life.	DO NOT	use retire	during most of w	UNNIG				
12	2		BOOK	KEEP	ER			ACCOUR	COUNTING		
Father's Name (First, Middle, Last						18. Mother's N	lame (First, Middle, Maiden Surname)				
ALTER	SYMONDS				ELIZ	LIZABETH NESERKE					
a. Informant's Name/Relationship (	19b. Meilir	leiling Address (Street end Number or Rural Route Number, City or Town,					State, Zip	Code)			
DOROTHEA TUOHY - DAUGHTER 30638 E. RUSTIC DR. SALISBURY, MD 21804							1804				
20a. Method of Disposition 20b. Place of Disposition (Neme of competing competing competing competing of other place)						icel	Date	20c. Location -	City or To	wn, State	
1 Burial 2 Cremation 3	Removal from Stel	9					11/4/00	CAMBRID	GF M	ARYLAND	
4 Donetion 5 Other (Specify) CAMBRIDGE CREMATORY 11/4/00 CAMBRIDGE, MARYLANI 21. Signeture of Fundal Service Licenses 22 frame and Address of Facility 705 E. MAIN ST.											
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1											
BOUNDS FUNERAL HOME, INC. SALISBURY, MD 218  23a. Perty Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only price cause on each line.  Approximately and Bellines.											
Immediate Ceuse (Finel disease or condition resulting in deeth)  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):										Days	
Sequentially list conditions, if eny, leeding to imediate cases. Extra United to the conditions of the									100		
Cause (Disease or injury that initiated events Due to (or as a consequence of):											
			9.00								
t ii. Other significant conditions of	contributing fo death	buf nof res	ulting in the u	inderlying	cause gi	ven in Part I.		23b. Did tobacco use contribute to the ca			
ENO STAC	e De	men	200				1	Yee 2 No	3 Pro	bably 4 Unk	
					1		24a. We	s an eutopsy ormed?	ev	ere autopsy findir eilable prior fo impletion of causi deeth?	
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							10	Yes 21 No	1 [	Yes 2 No	
examiner?	Hospitel:				0	-	eath (Check only	one)			
1□ Yes 2☑No	1 Li Inpa				NOA	4 Mursing	-			<i>(y)</i>	
1 Netural 5 Pending investigation	n	Jury Dey Year)	28b. Time of Injury	M M			28d. Describe	now injury occur	790		
3 Suicide 6 Could not be determined	256. PIECE OF	Injury - At ho etc. (Specif	ome, farm, str	reet, facto	ry, office				per or Rura	Il Route Number,	
	miner: On the basis	of examine									
29a. Certifier (Check only one)  29b. Signeture and fill of orbitals  29c. License number  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.  29b. Signeture and fill of orbitals  29c. License number  29d. Date signed (Month, Day, Year)								29d. Date signe	d (Month,	Day, Year)	
or ordinarare allo transpir delitring	and the second	D-39813 11/2/a									
S. Signature and Industry	- dr	10			D	39813		11/0	10	5	
· lla					D	39813		11/2	1/0	U	
Name and eddress of person who	completed cause of	f deeth (Item					MD 21	/// Z 804	1/0	U	
rt	was case referred to medical examiner?  I yes 2 No  Menner of Death  Menner of Death  Menner of Death  Menner of Death  Could not to determine to de	was case referred to medical examiner?    Was case referred to medical examiner?   West of the conditions of the conditi	Due to (or control of the conditions of the cond	Due to (or es a consections, ny, leading to immediate itse. Enter Underlying use (Disease or injury trinitated events ulting in deeth) Lasf  Due to (or es a consection in the unit of the	Due to (or es a consequenca of puentially list conditions, ny, leading to immediate see. Enter Underlying use (Disease or injury trinilated events ulting in deeth) Lasf  Due to (or as a consequence of puential to the conditions of the conditions	Due to (or es a consequenca of):    Due to (or es a consequence of):	Due to (or es a consequenca of):  Due to (or es a consequenca of):  Due to (or es a consequence of):  Due to (or as a consequence of):  Due to	Due to (or es a consequence of):  C. Due to (or es a consequence of):  Due	Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or as a consequence of):  Due to	Due to (or es a consequence of):  Due to (or as a consequence of):  Due to	

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ROY 03 2000 Senson in spine

State of Marvland / Department of Health and Mental Hygiene

128-031	State of Maryland /	Department of Health and
mend item 23a,27,28a,bc,d,e,f	per me G789 11/28/00 yf	Certificate of Death

Physician	1. Deceden	t's Nama (First, Middle,			Certificate of	Death	2. Dete of De	Reg. No.	3. Time of Death	
		Jack Edv	ward Poulte	r. Jr.			OCTOBE	R 27, 20	00 1300 PM	
/Medical Examiner		Nama (If not institution, 9	give street and number)			4b. City, Town, or BETHESDA		4c. County		
Funeral Director	213-8	4-6666	4VIM OFF	ga (In yrs. last birtl 39 Y	nday) If Under 1 Yaa Months Dey			th y, Year) , 1961	9. Birthplace (Steta or Fore Country) Maryland	
N III	10e. Stete	dence of Decedent 10b. County		10c. City, Town	or Location				10d. Inside City Lim	
to to	Maryl	and Montgom	ery	Bethese	la				1 ☐ Yes 2 🔀	
be notified Director	10e. Street	and Number			10f. Zlp Code			10g. Citizen of W	het Country?	
234	49	970 Battery	Lane #208				J	tates		
natural, or items 23e or 28e-f show dies Examiner must be notified at sted by Funeral Director	3 □ Wid	Status rer Merried 2 Merried lowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 1 Yes, Give Year or Detas:		U.S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or It Yas, specify Cuben, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ☒ No Specify:				- American Indian, k, Whita, atc. White	
ygiene.  or than *natural',  r, me Medical Ext.  Completed by	Elemente	15. Decedent's (Specify only highest pry/Secondery (0-12)		5+)	16e. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use retired)  Exterminator				siness/Industry	
ISE A	17. Father's	Neme (First, Middle, La K Edward Pot		EA	cerminator	18. Mother's Ne		Maiden Sumam		
is marks		ant's Name/Reletionship					A Meltzer  Rurel Route Number, City or Town, State, Zip Code)			
5 2	Jason	n E. Poulte	r/Brother	390	08 Norris I	rive, Fre	edericks	burg, Vi	rginia 22407	
5= 5	1 Buriel 2 X Cremetion 3 Removel from State cemetery, cremetory or other place) Nov. 4,							City or Town, Stete		
Department Important: I any Injury o	21. Signatu	re of Funeral Sarvice Lie	rensee	M00198	22. Nama and Add Robert A. P 7557 Wiscon	umphrey Fur			-Chevy Chase, In	
nysician Medical xaminer				INTOXICAT	ION	ying, such es cardia	c or respiretory a	rrest,	Approximete Intervel Between Onset end Deeth	
in and instrument Examiner	Sequentiallif any, leadicause. Ent Cause (Disthat initieted resulting in	ly list conditions, ing to immediate ler Underlying ease or Injury d events death) Lest	b	Due to (or as e c						
or use	Port II Othe	r elanificant conditions	contribution to death h	ut not reculting in	the underlying squee	riven in Dert I	23h Did	tobacco use con	tribute to the cause of dea	
ed by the attandin detached for use y Physician/W	Pert II. Other	er elgnificant conditions	contributing to death b	ut not resulting in	the underlying cause (	given in Pert I.		tobacco uae con Yee 2□ No	atributa to the cause of dec 3 □ Probably Unkn	
igned by the attandin be detached for use by Physician/M	Pert II. Other	er elgnificant conditions	contributing to death b	ut not resulting in	the underlying cause of	given in Pert I.	1 🗆 24e. Wes		10	
ate has been signed by the attandin page 2 should be detached for use Completed by Physician/N	Pert II. Other	er eignificant conditions	contributing to death b	ut not resulting in	the underlying cause (	given in Pert I.	1 🗆 24e. Wes	Yee 2□ No	3 Probably Unkn  24b. Were autopsy tinding evallable prior to completion of cause	
ate has been signed by the attandin page 2 should be detached for use Completed by Physician/N	25. Wes care examine	se reterred to medical		ut not resulting in		26. Plece of De	1 🗆 24e. Wes	Yee 2□ No en eutopsy med?  Yes 2□ No	24b. Were autopsy finding evallable prior to completion of cause of death?	
his certificate has been signed by the attendinal director, page 2 should be detached for use To Be Completed by Physician/N	25. Wes can examine 1 X Yes	se reterred to medical er? s 2 No	Hospitel: 1 ☐ Inpatie	ent 2□ER/Out	patient 3□ DOA C	26. Plece of De Other: 4 ☐ Nursing I	24e. Wes perfo	en eutopsyommed?  Yes 2□No one)  dence 6 X Othe	24b. Were autopsy finding evallable prior to completion of cause of death?  Des 2 No  or (Specify) AT SCEN	
this certificate has been signed by the attending director, page 2 should be detached for use To Be Completed by Physician/N	25. Wes care examine 1 2/2 Yes 27. Manner 1   Nett 2   Acc	se reterred to medical er? s 2 No of Deeth urel 5 Pending cident investige	Hospitel: 1 ☐ Inpatie 28e. Date of Inju- formation 10/	ent 2□ER/Out iry y Year) 28b. T four 27/00	patient 3 DOA Comme of P 28c. In William 112:45	26. Plece of De Other: 4□ Nursing I jury at ork? □ Yes 2 ☑No	24e. Wes performed to the control of	Yes 2 No Yes 2 No one)  dence 6 X Othe how injury occurr	24b. Were autopsy tinding evallable prior to completion of cause of death?  Des 2 No  or (Specify) AT SCEN	
ar death. rector: After this certificate has been signed by the attandin by the funeral director, page 2 should be detached for use tiffication: To Be Completed by Physician/N	25. Wes care examine 1 💢 Yes 27. Manner 1 🗆 Netr	se reterred to medical er? s 2 No of Deeth urel 5 Pending cident investige icide 6 SCould no	Hospitel: 1 ☐ Inpatie 28e. Date of Inju- formation 10/	ent 2 ER/Out iry 28b. T four 27/00 iury - At home, ter c. (Specify)	patient 3 DOA cime of P 28c. In	26. Plece of De Other: 4□ Nursing I jury at ork? □ Yes 2 ☑No	24e. Wesperfo	Yes 2 No  No neel outopsy ormed?  Yes 2 No  No neel outopsy occur  dence 6 X Other how injury occur  Street and Numb wm, Stete) 4970	24b. Were autopsy finding evallable prior to completion of cause of death?  Des 2 No  or (Specify) AT SCEN	
his certificate has been signed by the attendinal director, page 2 should be detached for use To Be Completed by Physician/N	25. Wes carexamine 1 X Yes  27. Manner 1 Net 2 Acc 3 Sui	se reterred to medical er? s 2 No of Deeth urel 5 Pending investige iciden determine	Hospitel: 1 Inpatie  28e. Date of Inju foundity. De ion the ad 28e. Plece of Inju building, et	ent 2 ER/Out  17 y Year) 28b. T  27/00  1 jury - At home, ter  1. (Specify)  1. exemination and  2 ent 2 ER/Out  2 b. T  4 four  2 c. (Specify)  1 exemination and	patient 3 DOA compared by the patient of P 28c. In Williams, street, tectory, office death occurred et the	26. Plece of De  Other: 4□ Nursing livry at ork? □ Yes 2 ☑No e  time, date and plec	24e. Wes perfet (Check only of the Check only only only only only only only only	Yes 2 No  yes 2 No  one)  dence 6 X Othe how injury occurr  Street and Numb wn, Stete) 4970 hesda, MD  ceuse(s) end me	24b. Were autopsy tinding evallable prior to completion of cause of death?  Des 2 No  or (Specify) AT SCENed  er or Rural Route Number, Battery Lane Autopsy Lane	

**DHMH 16 Rev 6/95** 

State Registrar

31. Data filed (Month, Day, Year)

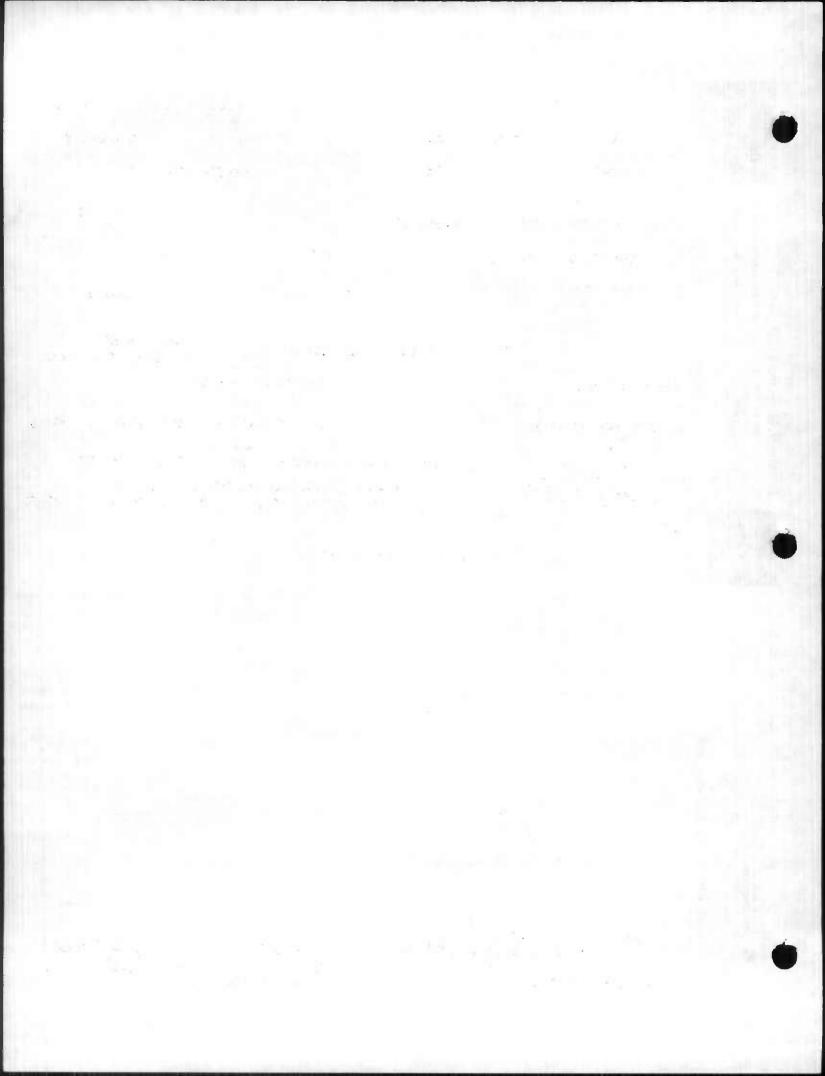
32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death ^{Day} 2000 Month NOV **Physician** JUDITH LORRAINE PAUL 2 1:55 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Yaar) If Undar 1 Yaar 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplaca (Stata or Foraign Country) **Funeral** Months Deys 1 M 2 F 209-14-2868 75 Yrs 04-30-1925 PA **Director** Usuel Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show treumstic event, the Medical Examinal must be notified at X Yas 2 No Directo MARYLAND MONTGOMERY CHEVY CHASE 10g. Citizan of Whet Country? 10e. Street end Number 10f. Zip Coda 20815 USA 8101 CONNECTICUT AVE #S601 Funerai death 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. Pages 1 end 2 should be filed within 72 hours after onent of Health and Mental Hyglene. Int: If Itam 27 Is marked other than "naturel", or ites 1 ☐ Yes 2 ☐XNo If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1□ Yas Ž□ No Maryland 21215-0020 Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) College (1-4or 5+) CHEVY CHASE Elamentery/Secondary (0-12) OFFICE ADMINISTRATOR RECREATIONAL CENTER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be GERTRUDE LIPSHITZ SAMUEL SCHATZ 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 8101 CONNECTICUT AVE #S601, CHEVY CHASE, MD 20815 other 1 ALBERT PAUL/HUSBAND Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata NOV 03. 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from Stata ò permit. Page Department of Important: If any Injury or once. 5 Othar (Spray) 2000 4 Donetion METROPOLITAN CREMATORY ALEXANDRIA, VA 22. Name and Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. P. 11. Entar tha disaase, or complications that caused tha death. Do not anter tha mode of dying, such as cardiac or respiratory errest, bock, or heart failure. List only one cause on each line. Approximete Intarval Batwean Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting in daath) /Medical CEREBRAL VASCULAR ACCIDENT Examiner Due to (or as e consequence of): Examiner certificate be executed physician and the bunal-tran Sequantially list conditions, if any, leeding to immadiata causa. Entar Undarfying Causa (Disaasa or injury that initiated avants resulting in death) Lest Dua to (or as a consaquance of): Box 68760 Physician/Medicai Dua to (or as a consequence of) 80 950 for 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed by Division of Vital Records. by 8 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to Completed peen complation of cause of deeth? has page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, Be 25. Was case refarred to medical axaminer? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Tyas 2 No 1) Inpatiant 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral Certification: 27. Mannar of Death 28d. Dascriba how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending investigation 1 X Natural 1 ☐ Yas 2 ☐ No death. 2 Accident after death 6 ☐ Could not be detarmined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) filled in by 4 - Homicide 24 hours Hospital 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and place, end due to the cause(s) and mannar es stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated. (Check only one) To the F within 2 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifiar M.D 2000 9900246 (NC) 30. Name end addrass of person who complated cause of death (Itam 23e) (Type, Print) NATIONAL NAVAL MEDICAL CENTER E.D.HIGH, LT, MC, USNR BETHESDA MD 20889-5600 31. Dete filed (Month, Day, Yaar) 32. Registrar's Signatura State 06 2000 oaks Registrar

DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_				OI IVIAI		ertificat		Death		Reg. No.	J J	/166		
Physicia /Medica	- 1	1. Decedent'e Neme (First, Mic GRETCHEI			PIS	TER			2. Dete of De Month NOVEMBE	eth Dey 7,	2000	3. Time of Death 2:16 AM		
Examine		4e. Facility Neme (If not Institute BEDFORD COUR						4b. City, Town, or L SILVER SI			of Death	Υ		
Funeral Director		5. Sociel Security Number 579 44 2166	6. Sex 1 □ M 2 万 F		In yrs. lest birthde 4 Yrs.	/) If Under Months	1 Yeer Deys	If Under 24 Hrs. Hours Min.	6. Dete of Bir FEB 9,	th 1906	9. Birthple GERMA	ece (Stete or Foreign		
yland		Usuat Residence of Decedent  10e. Stete 10b. Cour	nty	11	Oc. City, Town or I	_ocation					10	d. Inside City Limits		
Series	ctor		ITGOMERY		ASHT0							1 ☐ Yes 2 ☑ No		
oth with the 23a or 2	Funeral Director	10e. Street end Number 18727 NEW HAM	IPSHIRE AV	ENUE		10f. Zip	Code	20861		10g. Citizen of V UNITED		*		
aryland 21215-0020  About be filed within 72 hours efter deeth with the Meryland and Mentel Hygiene, merked other than "netural", or items 23s or 28s-f show immits event, the Medical Examiner must be notified at	p	11. Meritel Stetus  1☑ Never Merried 2☐ M  3☐ Widowed 4 ☐ Divorce	Armed 1 Ye If Yes,	ecedent Eve Forces? s 2 No Give r Detes:	er in U,S.	Wes Deced If Yes, spec		dispanto Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)	Yes or No- n, etc.) 14. Race - An Bleck, Wi Specify: W		etc.		
Baltimore, Maryland 21215-0020 semit. Pages I and 2 should be filed within 72 hours ef spearment of Health and Mentel Hygiene. mportant: If Nem 27 is marked other than "netural", or ny injury or other traumatic event, the Medical Examples.	Be Completed	15. Deced (Specify only hig Elementery/Secondery (0-12	lent's Education hest grade complete  College	d) a (1-4or 5+)	(Giv	edent's Usua le kind of wo DO NOT us USEKE	rk done se retire	pation during most of wor d)	king		nd of Business/Industry			
/land uld be filed Aentel Hygride othe	To Be C	17. Fether's Neme (First, Middle FRANTZ	PISTER		- '			18. Mother's Nen CLARA		, Middle, Melden Surneme) BESSENBECK				
Mary 12 shou 12 shou 1s mai raums		19e. Informent's Name/Reletio				-	,	set end Number or Rural Route Number, City or Town, Stete, Zip Code)						
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiena. Important: If Item 27 is marked other than any injury or other traumatic event, the Ma		ANNA C. ROGNL  20e. Method of Disposition  1 Buriel 2 Cremetio  4 Donetion 5 Other	n 3 Removel fro		cemetery, cremetory or other place)					20c. Location -	vn, Stete			
Baltir permit. P Departme importan any injur pace.		21. Signeture of Funerel Service	ce Licensee	Doul	2	22. Name er MIIR T F 1	nd Addre	ss of Fecility RARRER I	FUNERAL	HOME				
		23a. Pert1. Enter the disease, shock, or heert failure. L	or complications the	ot caused the	e death. Do not e	P.O. I	30 X le of dyli	5038, LAY	TONSVIL or respiratory e	LE, MD.	2088	Approximete Interval Between		
Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)		rther		stu 1		t Di				Years		
6876( ficate be physicals st the bur	physician and strength and the butal-transit edical Examiner	edicai	edicai Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	6	Du	e to (or es a conse	equence of):						
Box (sauth certification of for use e	ician	Pert II. Other significant condi	itions contribution to	dooth but o	not reculting in the	undonline	auna ah	ron la Bart I	ash Did	tohacco use co	ntribute to	the cause of death?		
Is, P.O. Box es thet the death cer igned by the attendir be detached for use	by Physician/M	Diesetes	mellitus		of teaniting at the	underlying c	ause gn	ven in reitt.		Yes 2 No	3 Prob			
aw requir	Completed	Hypertens	/ em						24e, Wes	en eutopsy med?	con	re autopsy findings llable prior to apletion of cause eath?		
f Vital R	5			14						Yes 2 No	10	Yes 2 No		
r Vit ysicia is certi directe	0 26	25. Wes case referred to mediexaminer? 1 ☐ Yes 2 ☐ No	Hospitel:	☐ Inpatient	2 ER/Outpati	ent 3 DC	DA Oth	26. Place of Dee		one) dence 6 🗆 Oth	er (Specify	)		
Sion o	ation:	E LI MODICIONI	ding (M stigetion	te of Injury onth, Day Y	(ear) 28b. Time Injury	of M	28c. Injui Woo			how injury occur				
2 25 2	Certification:	3 Sulcide 6 Coulded	mined 289. Pie	ce of Injury ilding, etc. (	- At home, ferm, s Specify)	treet, fector	y, offica		26f. Location ( City or Tot	Street end Numb wn, State)	er or Rural	Route Number,		
To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29e. Certifier (Check only one) 1 ☐ Certify 2 ☐ Medic	ying Phyelclan: To t al Examiner: On the end m	he best of m basis of ex enner steteo	aminetion end/or i	th occurred nvestigetion	et the ti	me, date end pieca plnion, deeth occu	, end due to the rred et the time,	ceuse(s) end ma date and plece,	anner as ste end due to	ited. the cause(s)		
To the comple	Me	29b. Signature and title of certification		1	pn	290		33359	+	29d. Date signe	d (Month, E	ley, Year)		
0 m		30. Number and eddress of pers	on who completed ca na Tha	use of deet	h (Item 23a) (Type	e, Print)		-53e W	15 consir	Ave	CL	my Chase		
State Registra	1	31. Dete filed (Month, Dey, Yes		. Registrer's	Signeture	An	uko	,				1		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** 7:00 AM November 4, 2000 Marie Plannett Price /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Name (If not Institution, give street and number) Examiner Baldwin Baltimore Dulaney Valley Assisted Living H Under 1 Yaar | H Under 24 Hrs. | 8. Dete of Birth (Month, Dey. Year) | Hours | Min. | June 21, 1914 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months 86 Pennsylvania Director 208-07-9127 Usual Residence of Decedent r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Cockeysville MD Baltimore 1 Yas 2 No Directo 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itsens 23a or edical Examiner must be 21030 600 Knollcrest Place United States Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yaer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, etc. 1 Nevar Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White þ 3 N Widowed 4 □ Divorced Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Line Worker Bendix Company marked other 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middla, Last) Be should be Mental Ralph Minerd Violet Summy 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Pages 1 and 2 s ment of Health an of Health Item 27 Michelle Steedman / Granddaughter 10104 Daventry Drive Cockeysville, MD 21030 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta 20e. Method of Disposition Department of Important: If is any injury or o 1 ☐ Burial 2 【Cremation 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) Chesapeake Crematory, Inc11/6/00 Beltsville, MD 22. Nama and Addrass of Fecility CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Tows Towson, MD 21286 23a Fart Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying, such as cardiac or respiretory errest, and the mode of dying are cardiac or respiretory errest, and the mode of dying are cardiac or respiretory errest, and the mode of dying are cardiac or respiretory errest, and the mode of dying are cardiac or respiretory errest, and the mode of dying are cardiac or respiretory errest, and the mode of dying are cardiac or respiretory errest, and the mode of dying are cardiac or respiretory errest. Approximeta Intervel Between Onset and Deeth **Physician** Zheimers DITTAGE Immediate Cause (Final disease or condition resulting in death) /Medical UEAMS Examiner Due to (or as a consequence of) Age Examin attending physician and for use as the bunal-transit requires that the death certificate be executed Sequantielly list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury that initiated events rasulting in deeth) Last Due to (or es a consequenca of): Box 68760. Physician/Medical Dua to (or as a consaquance of): ed by the a 23b. Did tobacco use contribute to the cause of death? P.0. Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records, by 24b. Wara autopsy findings available prior to should b 24a. Was en autopsy performed? Completed completion of cause of death? The law page 2 s certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No Physician: 25. Wes case referred to medical 26. Placa of Deeth (Check only one) Be Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Wother (Specify) 1755 1549 Cluir 1 Yas 2 No 10 this funeral 27. Manner of Death 1 Neturel 28a. Data of Injury (Month, Dey Year) 28b. Time of Injury 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After Hospital or Attending 5 Pending invastigation 1 ☐ Yes 2 ☐ No death. 2 Accidant Director: / 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data end plece, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred et the time, data and place, and due to the cause(s) and mennar stated. 29a. Certifier edical 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number Sor MAZIAND NOV 5, 2000 D15871 6 30. Name and address of person who completed causa of death (Item 23e) (Type, Print) 54 Scott ADAM Rd Cockeysville Md 21030 LAWTENCE BOAS MD

DHMH 16 Rev 6/95

State

Registrar

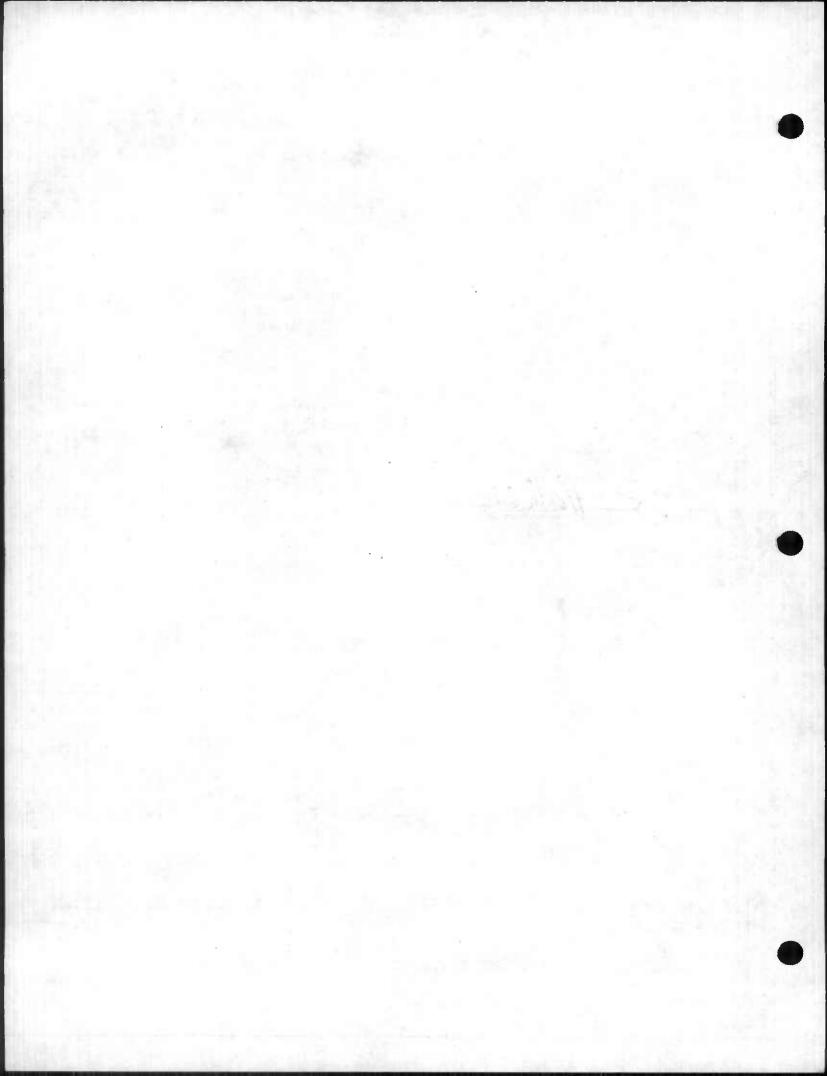
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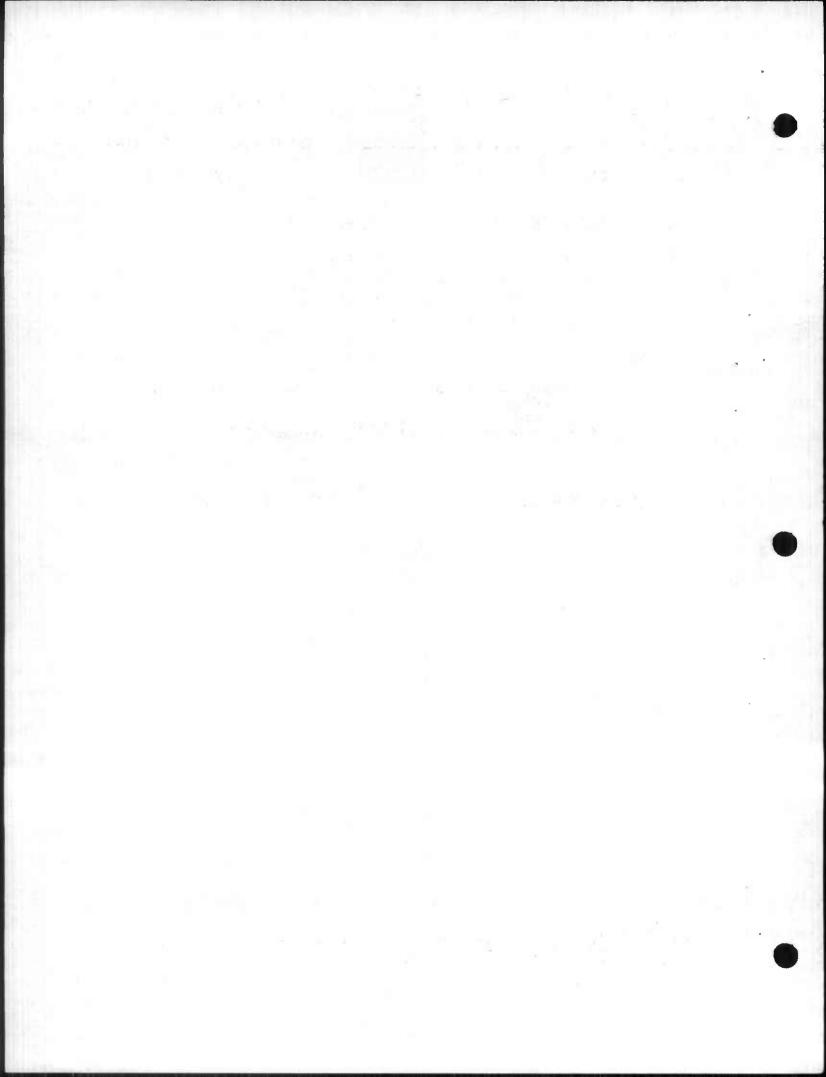
32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene ?

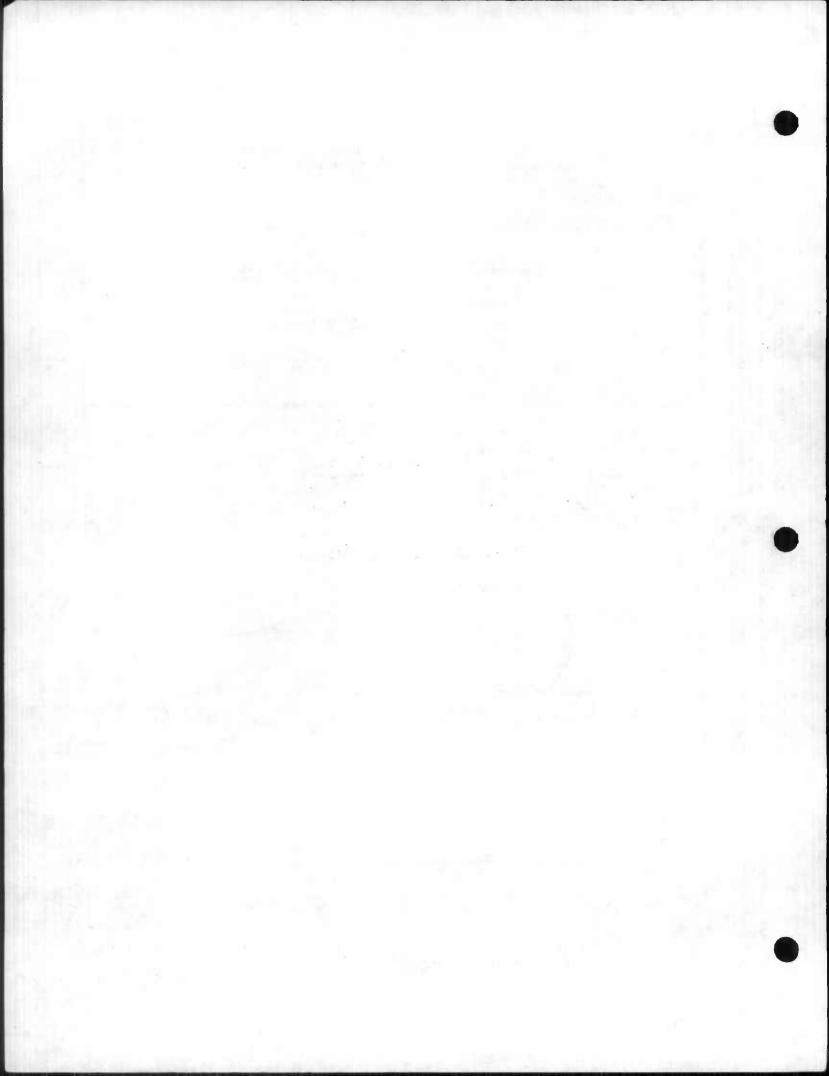
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	vith th	Dir	10e. Street end Number			101	f. Zip Code	,		log. Citizen of	What Count	try?	
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020	be filed within 72 hours after death with the Maryland tel Hyglene. d other than "natural", or flems 23s or 28s-f show event, the Modical Exeminer must be not led at	by Funeral Director	11. Markel Stetus  1 □ Never Merried 2 □ Merried  3 ☒ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 ∑ Yes 2 ☐ No If Yes, Give Yeer or Detes:	1952		specify Cub	Hispanic Origin? (S an, Mexican, Puert Specify:	pecity Yes of No- o Rican, etc.)	14. Reca - American Indie Bieck, White, etc. Specify: White			
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m	89 2 2 8		Clarkell Bur	Jefferson Chapel Funeral Home PO Box 838, Charles Town, WV 25414									
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State of Maryland / Department of Health and Mental Hygiene

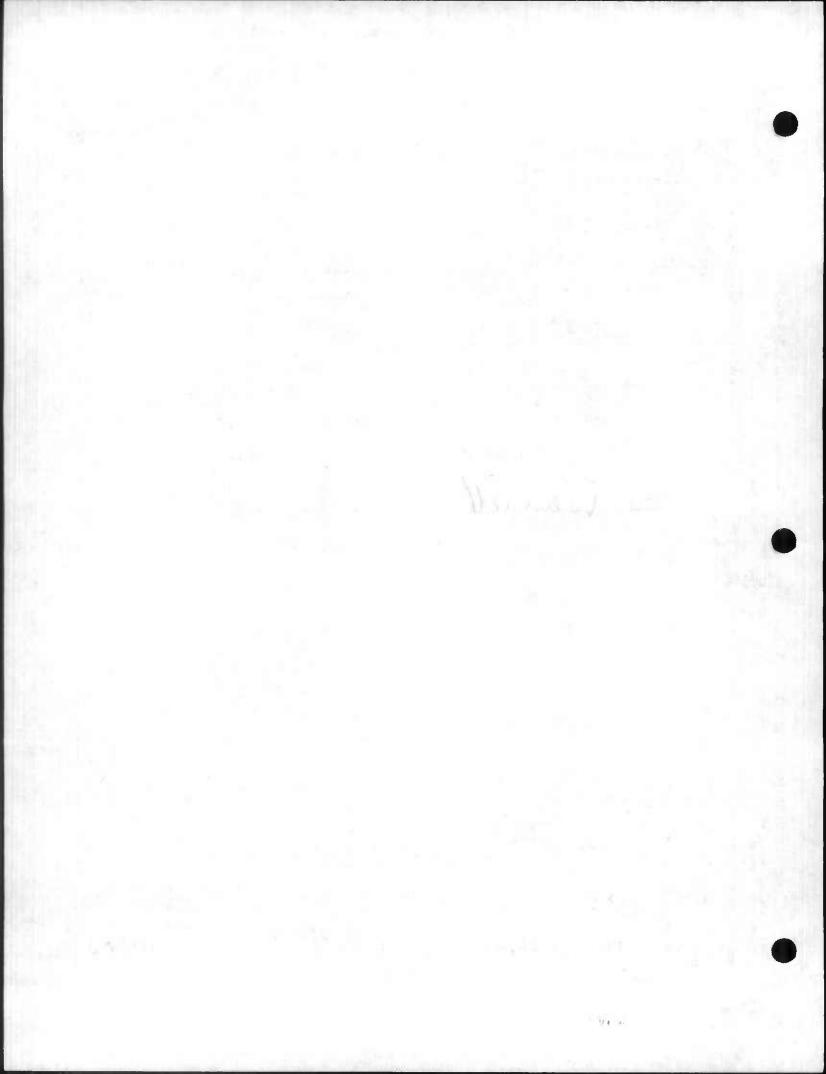
	Certificate of Death	Re	g. No.	37169						
	Decedent's Neme (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death						
Physiciar /Medica	RITHEL V REED	Nov. 8	, 2000	520 bw						
Examine	46 City Town or Lo	cation of Death	4c. County of Deat	h						
	Wezzy Willow Chestert	own	Kent							
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th with t	10e. Street end Number 10f. Zip Code 19714-9682	10	og. Citizen of What Co USA	untry?						
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Dor.	9 homemaker		own home	3						
O EISE	17. Father's Neme (First, Middle, Last)									
aryia should the marked umaric	Atwood Hanna Alice	Holli								
Maryian d 2 should be th and Mental 7 le marked o traumatic eve	19a. Informant's Name/Reletionship (Type, Print)  19b. Meiling Address (Street end Number or Rura	il Route Number,	City or Town, State, 2	ip Code)						
	Charles Reed (son) P.O. Box 9682 Newa	rk, DE	19714-96	582						
M A 40 O	20a. Method of Disposition  20b. Plece of Disposition (Name of cemetery, cremetory or other place)	Dete 2	Oc. Location - City or	Town, Stete						
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6876C	that initiated events Due to (or es a consequence of):									
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death cert e attending ed for use										
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Rec e law has b ge 2 s			V	of death?						
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Physic of this contain direction of the this contain direction of the this contain of the third	1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 Reside	nce 6 Other (Spe	city) care hom						
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DIVISION Attend after death Director: A in by the in the incorporate of the incorporate o	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, farm, street, factory, office bullding, etc. (Specify)	28f. Location (Str. City or Town,	reet and Number or Ru , Stete)	iral Route Number,						
o de la composición del composición de la compos										
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To the Hospital or / within 24 hours after To the Funeral Dire completely filled in E	and the state of t	29	d. Date signed (Mont	). Dey, Year)						
	1 / M MD MD D0051786 11/8/00									
E	30. Name end address of person the completed cause of death (Item 23a) (Type, Print)	1	4.1	0						
0	120 Speer Road Suite # 2 Che	sterto	own M	0 21620						
State Registrar	31. Dete filed (Month, Dey, Year)  32. Registrer's Signeture									
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State of Maryland / Department of Health and Mental Hygiene [ ] 37170

	Certificate of Death	Re	g. No.							
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Physician /Medical	BERTHA ELIZABETH RASIN	NOWEMBE			3:15 AN					
Examiner	Saint Joseph Medical Center Tows			of Death alti	more					
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Funeral etely lilled dical C	29a. Certifiar (Check only one)  1 Certifying Phyeician: To tha best of my knowledge, death occurred at the time, data and place (Check only one)  1 Certifying Phyeician: To the best of axamination and/or invastigation, in my opinion, death occurred and manner stated.	e, and dua to the ca urrad at tha time, da	use(s) and ma ata and place, a	nner as sta and dua to t	ted. ha causa(s)					
Toth	29b. Signetura end filled certifier Alexan Pett 1 29c. Licensa number D 34543	29	9d. Data signed	. 1 .						
	30. Name and address of person who complated causa of death (Item 23a) (Type, Print)	MARINE ST	111							
		MARYLA	ND 21	<b>204</b>						
State	31. Data filad (Month, Day, Year) 32. Ragistrar's Signatura									
Registrar	NOV 0 6 2000 D. Aparts									
To the Eurous alreadors To the Europea Directors Completely lilled in by the	2 Accident 3 Suicide 4 Homicide  28a. Place of Injury - At homa, farm, street, factory, office  29a. Certifiar (Check only one)  1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  29b. Signeture end illest certifier  29c. License number	e, and dua to the ca urrad at tha time, da	use(s) and ma ata and place, a ed. Data signed	anner as sta and dua to t	ted. ha causa(s)					

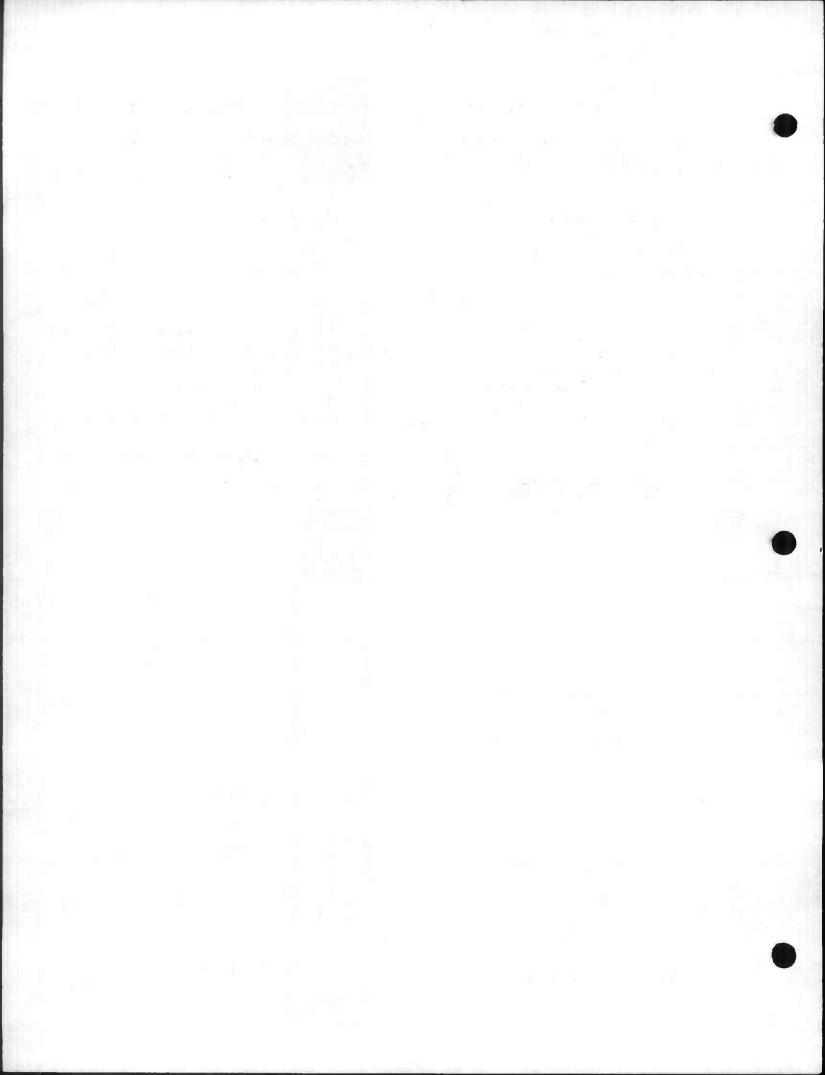
DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

							Certificate o	f Death		Reg. No.			
	Dhunial		1. Decedant's Nama (First, Middla, Las	st)					2. Data of Do		Yaar	3. Tima of Death	
	Physici /Medi		Charles	Estil R	oop						2000	10:45 pm	
	Examir		4a. Facility Name (If not institution, give	a street and number)				4b. City, Town, o	r Location of Dea	th 4c. Count	y of Death		
			Residence: 617 F						yville		Ceci		
ı	Funeral Director		213-14-0107	ax 7. Ag ☑M 2□ F	a (In yrs. I 79		rs. If Undar 1 Ya		n. (Month, D	rth ay, Year) 25, 1921	9. Birthi Coul M	place (Stata or Foreign ntry) aryland	
	pue *		Usual Rasidance of Decedant  10a. Stata 10b. County		10c. City	. Town	or Location					10d. Inside City Limits	
	Sa-f sho	Director	Maryland Cecil				F	erryville	e			1 X Yas 2 □ No	
	th with the 23a or 2	ral Dire	10e. Street and Number 617 Franklin Stre	et			10f. Zip Code	21903		10g. Citizen of	What Could	*	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pygiene. Important: If item 27 is marked other than "naturaf", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant   Armed Forcas? 1 ☒ Yas 2 ☐ If Yas, Giva Yaar or Datas:			13. Was Decedent of If Yas, specify C		Specify Yas or Norto Rican, atc.)	o- 14. Ra Blo Speci	ack, Whita,	can Indian, atc. White	
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highast grad	ucation de completed)		16e.	Decedent's Usual Occ	supation	orkina	16b. Kind of E	Businass/In	idustry	
2	ithin ne.	nple	Elamantary/Secondary (0-12)	Collega (1-4or 5	i+)		(Giva kind of work dor lifa. DO NOT usa rat					ng Ground	
7	led w lygier nt, th	Col	Twelve Years				Electronic					aryland	
and	ove the first	Be	17. Fathar's Nama (First, Middla, Last)	Clark Roo	2.50				ema (First, Middle		ma)		
Ž	d Me	To	19a. Informant's Name/Relationship (7		ЭÞ	105	Malling Address (Otto		Augusta		0	0.41	
e, Ma	and 2 s lealth an m 27 is r		Nellie B. Roop (w		T	61	Malling Address (Street) 7 Franklin	Street,	Perryvi	lle, Ma	rylan	d 21903	
Baltimore,	mit. Pages parlment of the cortant: If ite / Injury or of						ce of Disposition (Nama of Data 20c. Location - City or Town, natary, cramatory or other place)  Mark's Cemetery 11/8/00 Perryville, Ma						
Ball	Depart Depart Import any in		21. Signature of Funaral Sarvice United	2 Min	I.			rass of Facility atterson le, Maryl				e, P.A.	
			23a. Part1. Entar tha disaasa, or comp shock, or haart fallura. List only of	plications that cousad	the death	. Do n					,	Approximata Intarval Between	
8	Physician										1	Onsat and Daath	
r	/Medical Examiner		mmediata Cause (Final lisease or condition and ETASTATIC SMALL CELL CARCINOMA 6 MONTHS										
	Examino.	-	rasulting in death)		Dua to (or	asac	onsequence of):				}		
	pe ist	nlne		b									
, O	rtificate be executed ng physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, laeding to immadiata ceusa. Entar Undarlying Cause (Disaasa or injury	Dua to (or as a consequence of):									
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Box 6	ding p	95											
ă	that the death cer hed by the attendir detached for use	Physician/	Does II Oak and a life and a second			4.1							
o	the d	hys	Part II. Other significant conditions co	entributing to death be	it not rasu	iting in	tha undariying causa	givan in Part I.				o the cause of death?	
О,	signed b	by P							.   1	Yes 2□ No	3 ☐ Pro	bably 4 2 Onknown	
Records,	aw requisite parts to show	Completed to								s an autopsy ormed?	av co	are autopsy findings vallable prior to empletion of causa death?	
	ystclan: The la s certificate he director, page	E							1 🗆	Yas 2XXVo	1[	□ Yas 2□ No	
<u>=</u>	certificate	Be (	25. Was cese ratarred to medical axaminar?					28. Place of De	eath (Check only	one)			
> >	hysic al dire	2	1 ☐ Yas 2 ☒ No	Hospital: 1 ☐ Inpatia	nt 2 🗆 l	ER/Out	Detient 3 DOA		Homa 5 ☑ Ras	Idance 6 🗆 Ot	har (Specil	fy)	
Division of Vital	Attending Physician: or death. sctor: After this certific by the funeral director,	ation:	27. Manner of Deeth  1 Patural 5 Pending  2 Accidant Invastigation	28a. Data of Injur (Month, Day	Year)	28b. Ti In	jury V	jury at /ork? □ Yas 2 □ No	28d. Dascribe	how injury occu	rred		
Divis	or Atte	Certification:	3 Suicida 6 Could not be datarmined	28a. Place of Injubuilding, atc	ry - At ho	ma, fan	m, streat, factory, offic	9		(Street and Num wn, Stata)	ber or Aura	al Routa Number,	
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	edical (	29a. Cartifier (Check only one) 1 Certifying Phy 2 Medical Exam	raician: To the best of iner: On the basis of and manner sta	axaminati	rledga, on and	daath occurred at tha for invastigation, in my	time, deta and place opinion, daath occ	e, and dua to the curred at tha tima	ceusa(s) and m data and place	anner as s , and dua to	iteted. o tha causa(s)	
	To th Vithir Comp	Me	Sib. Signatura and titla of certified	dur	2	-1	29c. Lica	nsa number - 3/175		29d. Data sign		6, 2000.	
	12 TIVA		30. Name and address of person who c	omplated ceuse of de	eath (Item	23e) (1	ypa, Print) 311	2 SEL	AR A	CAND	210	47	
	Sta Registra		31. Data filed (Month, Day, Year) NOV 0 8 2000	32. Registre	r's Signat	ura	loods!	1	100				

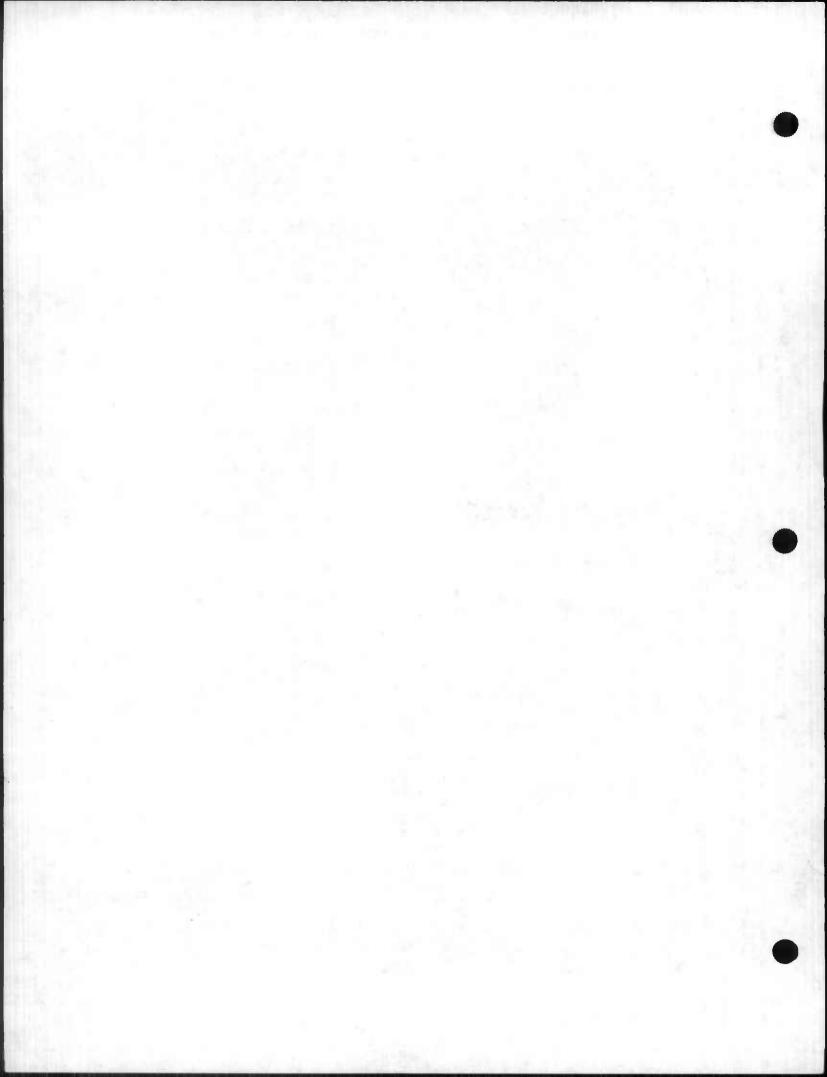
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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											Reg. No.				
	1. Decedent's Neme	(First, Middle, L	ast)			-1				2. Dale of De Month		V	ear	3. Time of	Deeth
Physician /Medical	William A	. Ralei	gh, Jr.							Novemb				8:41	am
/Medical Examiner	4e Facility Name (If			iber)			4	4b. City, To	own, or Lo	ocation of Deet		ounty of E	Death		
	Suburban	Hospita	1					Bethe	sda		Mon	tgom	nery		
Funeral Director	5. Social Security Nu 078-12-64		Sex 1 M 2 □ F	7. Age (In yrs. I 81	lest birthdey) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	8. Dete of Bir (Month, De Nov 8	th by, Year) 1918	9. Pe	Birthpla	ce (State o	or Foreig
	Usual Residence of														
ms 23a or 28a-f show	10a. State	10b. County		10c. City	, Town or Lo	cation							tod	I. Inside C	
16 0	Maryland	Montgom	ery	Bet	hesda		- 3	- 34					-	1 🗆 Yes	\$CIN
23a or 28a-1 show to nother a	10e. Street and Num	nber				101. Zip (	Code				10g. Citize	n of Wha	t Country	y?	
23 8	5721 Gros	svenor L	ane			208	14				USA				
than 'natural', or Name 23a or 28a-1 a ha Wadical Esamhet must be nothing ompleted by Funeral Director	11. Marital Stetus  1 Never Merrie 3 Widowed		12. Was Deced Armed Ford 1 X Yes If Yes, Give Yeer or De	ces? 2 No	4 - 0.	Was Decede If Yes, specif		lispanic Or en, Mexica Specify:		Specify Yes or No- rto Rican, etc.)  14. Rece - Americen Indien, Black, White, etc.  Specify: White					
Pd H		15. Decedent's I		105. 111111		dent's Usuel	Occup	ation			16b. Kind of Business/Industry				-
tal Hygiene. d other than "natury event, the Medical Be Completed	(Speci	ify only highest g	rade completed)		(Giva	kind of work DO NOT use	done	during mos	st of work	ing					
of Health and Mental Hygiene. If item 27 is merked other than or other traumatic event, the Mental Hygiene.  To Be Comp	Elamantary/Secon	ndary (0-12)	College (1-	4or 5+)	Edito			,		Publishing Company				nv	
and Mental Hygin la marked other aumatic event, II	17. Father's Neme (	First, Middle, Las			Darec	7.		18. Moth	er's Name	ame (First, Middle, Maidan Sumama)					
B C	William A							Myrt	yrtle F. Quick						
d Men					19h Mailir							Town State Zin Code1			
T la trau			nship (Type, Print)  19b. Mailing Addrass (Street and Number or Rural Route Number, City or Tow Leigh, III / Son  1705 Larchmont Blvd., Mt. Laurel, N								080				
Health em 27 ther tr	20a. Method of Disp		gn, 111	20b. P	lace of Dispo	sition (Nem	e of		4.,	Date					
iit. Pa	20a. Method of Disposition  1 Date  20c. Location - City or Town, Stete  20c. Place of Disposition (Name of cemetery, cremetory or other place)  4 Donetion 5 Other (Specify)  20c. Location - City or Town, Stete  1 1/9  Maryland Veteran's Cemetery 2000  Crownsville, MD														
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Depa my ir ans is	21. Signature of Fur	geral Service Lio	Brig00	1	22	<ol><li>Name end</li></ol>	Addres	ss of Facili	ItV	Funera	al Hom	ne, I	Inc.		
02.00	fas	HX.	free	M						d., W,				g, MD	20
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je l	resulting in death)		b. Mil-	ral	r as a consec	re_	S Le	gw	) gi	tation	<u>у</u>		>	Yea:	85
je je	resulting in death)		b. Mil-	ral	Valu	re_	s re	gw	zí	tation	Ч		>	Yea	85
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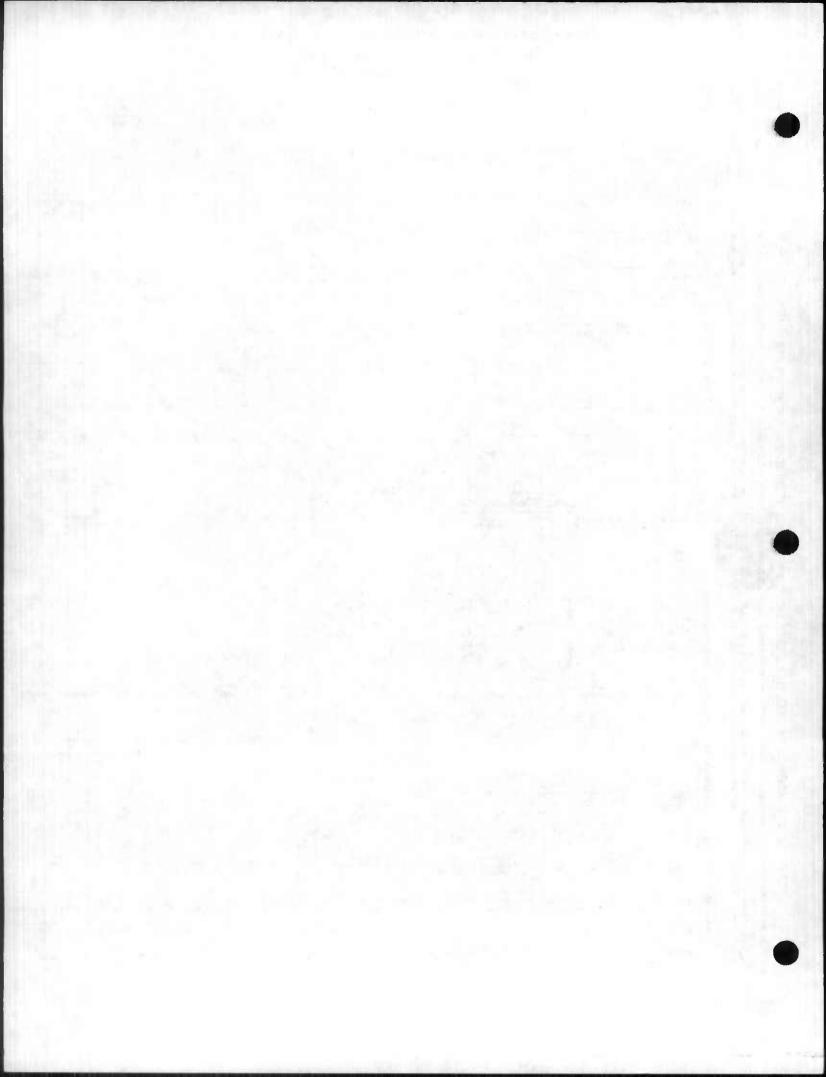


State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	40 1	Facility Neme (If not institution, giv	e street end number)				- 4	b. City, Tov	vn, or Lo	cation of Dea		County or		
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stician and spraining and spra	21.	Signature of Funeral Service Licer	E	7 77		T								
	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, N  23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
		quentially list conditions, ny, leading to immediate se. Enter Underlying use (Diaease or Injury Initiated events	b	Chronic Obstructive Pulmonary Di  Due to (or as a consequence ot):  Atrial Fibrillation  Due to (or as a consequence of):  Possible Malignancy						ease				
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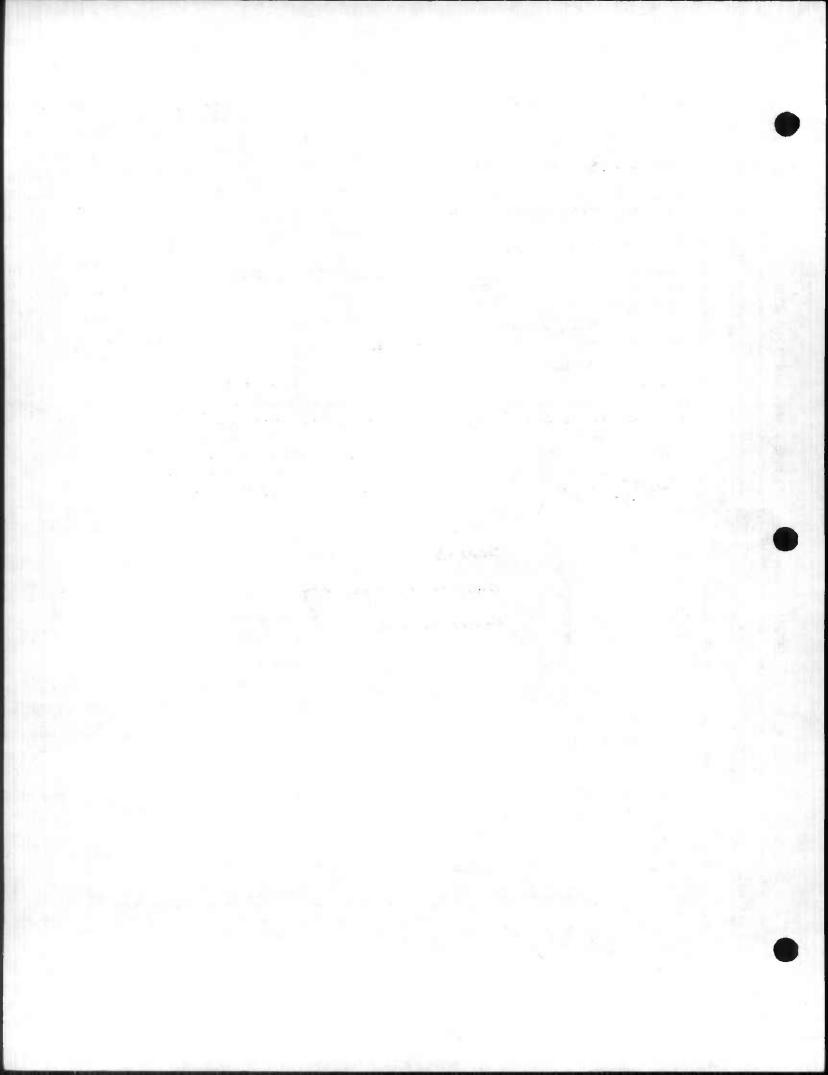


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month **Physician** Elizabeth E. Simmons 8, 2000 7:50P.M. November /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kt.on Cecil | Months | Days | Hours | Min. | Month, Day, Year) | Windows | Win. | Windows | Win. | Windows | 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-09-7066 1 □ M 2 😾 F 83 Yrs Director Maryland Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Maryland Ceci1 North East 1 N Yes 2 No Director 10f. Zio Code 10g, Citizen of What Country? 10a. Street and Number 6 400 East Cecil Ave. Apt. #1 21901 U.S.A. Herns 23s Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Bleck, White, etc. 72 hours after 1 Never Merried 2 Married White Baltimore, Maryland 21215-0020 1 Yes XONo Specify: "natural", or Specify q ₩idowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Paper 1 and 2 should be filed within Caparment of Health and Mental Hygiene. Important; if hem 27 Is marked other than any linjury or other traument. R.M.R. Corp. College (1-4or 5+) Elementery/Secondery (0-12) Laborer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be T.L. Lodge Edith Garrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Lawrence A. Simmons(son) 119 East Cecil Ave. North East, Md. 21901 20c. Location - City or Town, State 20e. Method of Disposition 20b. Place of Disposition (Name of Date 1 Buriel 2 Cremetion 3 Removel from State Immaculate Conception11/11/00 Cherry Hill, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Gee Funeral Home 21. Signature of E-259 E. Main St. Elkton, Md. 21921 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Seps 15 Examiner Due to (or es e consequence of): Examiner CAO/CARD romyopo+ that the death certificate be executed physicien and s the bunal-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Menal for line Box 68760 Physician/Medical Due to (or es e consequence of): for use as 23b. Did tobacco use contribute to the cause of death? Pert II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. the 2 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were autopsy findings available prior to been si 24a. Wes an autopsy performed? Completed completion of cause of death? hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To this 27. Menner of Death 28d. Describe how injury occurred Certification: 28a. Dete of Injury (Month, Day Year) 28h Time of 28c. Injury et Work? After or Attending 1 Neturel 5 Pending Investigation safter deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29e. Certifier Medical 🖎 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D0032395 11-13-00 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 14 Thomas E. Finucan M.D. 3 Mauldin Avenue, North East MD 2190 1 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State NOV 1 4 2000

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Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Examiner	4a Facility Name ( Berlin N				Cente	er			own, or Lo	ocation of Deetl		of Death ceste	r	
Funeral Director	5. Social Security N 214-28-1		. Sex 1⊠ M 2□ F	7. Age (In yrs. Ia	est birthday) Yrs.	If Under Months		If Under Hours		8. Date of Bird (Month, De March	22,1933	9. Birthp Coun	lece (State or Foreig try) MD	
daryland f show ind.st	Usuel Residence of 10a. Stete  MD	f Decedent 10b. County Worces	ster	10c. City	Town or Lo							1	0d. Inside City Limit	
with the Maryla e or 28e-f show be notified at Director	10e. Street and Nu	mber			202.23	10f. Zip					10g. Citizen of Whet Country?			
har death w r Herrs 23s signer must b Furneral I	10419 H	arrison		cedent Ever in U,S	S. 13. ¹		811 ent of F	lispanic Or	igin? (Sp	ecify Yes or No		S. e · Americ	an Indien,	
by by		ried 25 Married	Armed F	Forces? 2□No Army Sive	er in U,S.  13. Wes Decedent of Hispanic Origin? (St if Yes, specify Cuban, Mexican, Puerto  1 □ Yes 2 ☑ No Specify:					o Rican, etc.) Black, Whita, Specify: Bla				
ed within 72 hours at splens, or or than 'natural', or it, the Medical Exam Completed by I	Elementery/Seco	15. Decedent's city only highest ondery (0-12)	gre de completed	(1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Maintenance Person					16b. Kind of Be	Mote			
be file other of other event,	7th 17. Father's Neme Herbert			T Bat	P	ame	ı ıcıı ı	18. Moth	er's Nem		, Meiden Sumen		1	
	19e. Informent's N Martha S	eme/Reletionship	(Type, Print)			19b. Mailing Address (Street and Number or Rural 10419 Harrison Rd., Ber					er, City or Town,	Stete, Zip	Code)	
armit. Pages 1 ar Jepartment of Hea reportant: If Hem; my Injury or other MCS.	20e. Method of Dis	position 3	☐Removal from	n State Ce	lace of Disposition (Neme of emetery, cremetory or other place)					Date 20c. Location - City				
Deamit. Departments any inju	4 Donetion 5 Other (Specify)  St. Paul's Cemetery  11/4/00 Berlin, MD 21  21. Signeture of Funerel Service Ucensee  22. Name and Address of Fecility  Lewis N. Watson Funeral Home  1618 West Rd., Salisbury, MD 21801													
be death certificate be executed  We death certificate be executed  The attending physician and the for use as the burial-transit  Asician/Medical Examiner	Immediate Ceuse disease or conditive resulting in deeth)  Sequentially list or if any, leeding to it cause. Enter Und Cause (Disease or that Initiated event resulting in deeth)	(Finel on	a b	Due to lor	as a consection of a consectin of a consection of a consection of a consection of a consection	Auguence of the state of the st	o Lu	Vu osy	enieli	oniù etiè	n n	otilute t	Intervel Between Onset end Death	
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Physician: The this certificate and director, page 1: To Be Co	25. Wes case refe examiner?	THE PERSON A	Hospitel:	Inpatient 2 🗆 E	-D/O		Oth	or Y		th (Check only	one)	(Canad		
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the it Medical Certificati	29e. Certifier (Check only one)	1 Cartifying	Physician: To the aminer on the	ne best of my know basis of examineti	vledge, deetl ion and/or in	h occurred vestigation	et the ti	me, date e opinion, de	nd plece, eth occur	end due to the red at the time,	ceuse(s) and modete end place,	enner as s	tated. the ceuse(s)	
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State of Maryland / Department of Health and Mental Hygiene	00
Certificate of Death Beg No.	

ician		0: 1				Cerunc	ale of	Death			Reg. No.		2 Time of Paris
dical	Decedent's Name (First, Mide     HANS—CHRISTI		WILL	IAM	SC	HILLIN	NG			2. Data of De Month Octobe		2000°	3. Time of Death 12:17 Pt
	4a Facility Name (If not Institution 31655 Morris	13.12		er)				4b. City, To Parso		cation of Death		onty of Death	
al or	5. Social Sacurity Number 220–26–8640	6. Sex 1 🔀 M	Sex   7. Age (in yrs. id 1 ₺ M 2 □ F   71			hday) If U Mon	Indar 1 Yaar hths Days	If Under Hours	24 Hrs. Min.	8. Date of Bird Month, Da June I	0,1929	9. Birth	placa (Stata or Foreign ntry) Laware
-	Usual Residence of Decedent  10a. State 10b. Count			10c Cit	h. Town	or Location							10d. fnside City Limits
5		, icomic	0			onsbur					1 ☐ Yes 2 🖫 No		
ral Director	10e. Street and Number						1. Zip Code				10g. Citizen	of What Cou	ntry?
ō	31655 Morris	Leonar	d Rd				2184	9		- A	USA		
Funeral	11. Marital Status 12. Was Decedent Evar in U,S. 13. Was Armed Forcas?							_	gin? (Spe	ecify Yas or No Rican, etc.)		Raca - Ameri	
þ	1 Nevar Merried 2 Na 3 Widowed 4 Divorce	rried 1		□No Ar	No Army 1□ Yas				i, Puerto	riidan, etc.)		Black, Whita ecily: Whi	
P P	15. Decedent's Education (Specify only highast grade completed)						Usuel Occu	pation	t of worki	na	16b. Kind o	f Business/Ir	ndustry
Completed	Elementary/Secondery (0-12)		of work done OT usa retire	d)	I OF WORK	ing	-						
To Be Comp									4	deina Adiable	Jewe	-	
	17. Fathar's Neme (First, Middle Hans C	,	Schil	ling					izabe	(First, Middle, ≥th A	Maiden Sur nna	Yasil	k
	19a. Informant's Name/Relation					-	dress (Stree						
	Eileen S. Schi	111ng/	wile	201 6		31655 Morris Leo							
	20a. Method of Disposition 1 ☐ Burial 2 ☎ Cremation	200	20b. Placa of Disposition (Name of cametery, cramatory or other place)  Salisbury Crematory						tte 20c. Location - City or Town, State  20c. Salisbury, MD				
	4 Donation 5 Other (	Sal	LISD					11/1/00					
any in	21. Signature of Funeral Service	Licensee					_			ome Pro			ssociation
VMedical Examiner	resulting In death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	6		Due to (d	or as e c	onsequence	e of):						
clan	Date II Out and a local transfer of the same and				1.1.	w 1000 to 45 a				non Did	A-b		to the course of death
Phys	Pert II. Other significant condit	Ions contribu	ling to deat	h but not res	ulting in	the underly	ring cause gi	ven in Part I	•		Yes 2 4	/	to the cause of death
Completed by									an autopsy omed?	a	Vara eutopsy findings vailable prior to completion of cause of deeth?		
E										10	Yes 2 1	0 1	☐ Yes 2☐ No
Be	25. Was case referred to medic examiner?							-	of Deati	n (Check only	one)		
on: To	1 ☐ Yes 2 ☑ No  27. Manner of Deeth 1 ☑ Netural 5 ☐ Pend	Hospi 28	1 🗆 Inp	eatient 2 🗆 Injury Day Year)	ER/Out 28b. T	ime of	28c. Inju	iry at		Home 5 Assidence 6 Other (Specify)  28d. Describe how Injury occurred			ify)
Certification:	3 Suicide 6 Could	tigation d not be mined 28	le. Place of building	Injury - At h., etc. (Specil	ome, fer	m, street, fe		Yes 2	NO	281. Location (Street and Number or Rural Routa Numb City or Town, State)			
edical Ce		I Examiner: (		s of exemine						and due to the ed et the tima,			stated. to the cause(s)
Me	29b. Signature and title of certifi		o manna	Statati.			29c. Lican	se number			29d. Dete si	gned (Month	, Day, Year)
- 1		N	2				45	YLC?			11/11	00	
mo	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
Medical Certific	30. Name and address of person		ted cause	of death (Iter	n 23e) /	Type, Print)							

**DHMH 16 Rev 6/95** 

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							/ Depa		of H	lealth and M	Mental Hygi		0 3	37177	
Division	_	1. Decedent's Nam	e (First, Middle, La	st)							2. Dete of Deeth Month	Day	Year	3. Time of Death	
Physiciar /Medica		Raymond	Smith								Nov	05	2000	0520	
Examine		la Facility Name (	If not institution, gh	e street end i	nu <i>mber)</i>				4	lb. City, Town, or L	ocation of Death	4c. Count	y of Deeth		
S	Atlantic General Hospital Berlin									Worcester			er		
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Online 2 H Online 1 Year If Under 24 H Online 2 H Online 1 Year If Under 2 H Online 2 H												lece (Stete or Foreign try) MD	
D		10a. State	10b. County			10c. City, 7	Fown or Lo	cation					11	0d. Inside City Limits	
Many Many	ō	MD	Worcest	er		Ber	clin							1 XYes 2 No	
her death with the Maryland Herre 23e or 28e-f show foer must be notified at	Director	I0e. Street and Nu	mber	-				10f. Zip Co	ode		10	g. Citizen of	What Coun	try?	
38 o	2	300 Mapl	le Avenue					218	811			U.S	5.		
death death	Funeral	11. Marital Status		12. Wes D	ecedent l	Ever in U,S.	13.			ispanic Origin? (Sp on, Mexican, Puerto	pecify Yes or No-	14. Ra	ca - Americ		
Line of the second	2	1 Never Marr	ied 2 Married 4 Divorced	1 SYe	med Forces?  Yes 2 No Army res, Give par or Dates:			1 Yes, specify		Specify:	o Hican, etc.)	Speci	ry: Bla		
To the last	Completed	/Sna/	15. Decedent's E	ducation	dl	1	16a. Dece	dent's Usual C	Occup	ation during most of wor	king	6b. Kind of E	Business/Inc	lustry	
T H H	흔	Elementary/Seco	ondary (0-12)		(1-4or 5	i+)	life.	DO NOT use	retired	9	9				
N Page 1.	5	12th						Gro	und	skeeper			olfing	3	
D STEP O	e l	1000	(First, Middle, Last								ne (First, Middle, N		me)		
Maryland d 2 should be lie lith and Mental Hy T is marked othe traumatic event.	0		T. Smith				13				J. Powel				
to a man			eme/Relationship								ral Route Number,		, State, Zip	Code)	
	-		Smith/wi	ie		20h Bloo					lin, MD 2		Ch. or To	Ctate	
or at the	1	20a. Method of Dis 1 X Burial 2	position Cremation 3	Removal fro	m State	cem	etery, crer	sition (Name natory or othe	er plac			Oc. Location			
Part Part			5 ☐ Other (Special			Calv	-	UMC Cer		-	11/11/00	Berl:	in, MI		
Dallimore, peemit. Pages 1 a Dapathment of Hes important; if them any injury or othe since.		22. Name and Address of Facility Lewis N. Watson Functions 1618 West Rd., Sali:  23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart feiture. List only one cause on each line.									neral Hon	ne 1D 2180	01		
ficate be physicial is the burner	edical examiner	Immediate Cause disease or condition resulting In death)  Sequentially list confirm and in the Cause in the Under Cause (Disease or that Initiated events resulting in death)	onditions, nmediate orlying Injury	0	JEI	Due to (or as	s e consec s a consec	quence of):	Fo	iilure		Onset and Death			
death cert e attending el for use	and			d.									1		
Shed shed	) Sic	Part II. Other algnit	licant conditions	contributing to	death bu	ut not resultin	ng in the u	nderlying cau	se giv	en in Part I.	23b. Did to	bacco una c		the cause of death?	
ires that the de signed by the id be detached.	by Physician/M	Anox	ic ev	cep	ha	lopo	eth	4			1 🗆 Ye		bably 4 T Unknown		
he law requires e has been sign age 2 should be	Completed	EDD-STAGE RENAL DISEASE								24e. Was ar perform	n eutopsy ned?	av	ere autopsy findings ailable prior to mpletion of cause death?		
= - 50 0	3						172				1 ☐ Ye	s 2 No	10	Yes 2□ No	
certificate irector, page	9 2	25. Was case refer examiner?	red to medical					1117	Lou		th (Check only on	9)			
1 2 2 P		1 ☐ Yes 2 ☐ 27. Manner of Deat 1 ☐ Natural		28a. Da	Inpatie te of Injur onth, Day	ry 28	VOutpatier Bb. Time of Injury	280	Oth Unjur	4 U Nursing H	flome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
or Attending after death. Director: After d in by the fune	27. Manner of Death    Matural   5   Pending investigation   2   Accident   5   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28e. Place of Injury - At home, farm, street, factory, office   28e. Place of Injury - At home, farm, street, factory, office   28e. Place of Injury - At home, farm, street, factory, office   28e. Place of Injury - At home, farm, street, factory, office   28e. Place of Injury - At home, farm, street, factory, office   28e. Place of Injury - At home, farm, street, factory, office   28e. Place of Injury - At home, farm, street, factory, office   28e. Injury at   28e. Injury at										28f. Location (Street and Number or Rurel Route Number, City or Town, State)				
To the Hospital or Attent within 24 hours after deal To the Funeral Director: completely filled in by the Madical Certifical		29a. Certifier (Check only one)	1 Certifying Pr 2 Madical Exam	niner: On the	he best of basis of	examination	edge, deeti n end/or in	n occurred et vestigation, in	the tin	ne, date end plece plnion, death occu	, and due to the ca rred at the time, de	use(s) end note and plece	nenner as s , and due to	tated. the cause(s)	
0	age .	29b. Signature and	Title of certifier	anc	des	Vaco	_W.	29c. L	Licens	e number	() (-	Od. Date sign	ed (Month.	Day, Year)	
Rund	3	30. Name and addr	ass of person who	completed ca	use of de	eath (Item 2:	3a) (Type,	Print) FRAN	O K	KLIN /	Ave, F	BERL	12.	MD218	
State Registrar	=	31. Date filed (Mon	th, Day, Year) OV 0 9 20		Registra	ar's Signatur	° b.	Loc	21				1		

DHMH 16 Rav 6/95

REPORT OF THE PROPERTY OF THE

NOV 0 6 2000

	1. Decedent's No	ma (First, Middla, I	ast)			rtificate				2. Data of Dat	Reg. No.		3, Tim	a of Death
Physician	Antho		Charles	Schwart	7					Novembe	Day	n Xear		30 P.
/Medical		-	m or l	ocation of Death			12.	30 - 0						
Examiner		(If not institution, g mery Gene							ney		ty of Death	У		
Funeral	5. Social Sacurity		Sex	7. Age (In yrs. last b	irthday)	If Under Months	Year	If Undar 2			h v Year)	9. Birthp	place (Ste	ete or Foreign
Director	211-24-3		15₹M 2□ F	69	Yrs.	Months	Dujo	110010	.,,,,,	8. Data of Birth (Month, Day, Year) Jan. 7, 1931 9. Birthplace (State Country) Pennsylva:				
pue }_	Usual Rasidance	10b. County		10c. City, To	wn or Lo	cation						1	0d. fnsld	le City Limits
the Maryler 28s-f show rout at	36	Montgo	mery	Rock							- 3			Yas 2□No
or 28	10e. Street and N	lumber		10g. Citizan of	What Cour	ntry?								
23a 23a	14012	Castaway	Drive								United	Stat	es	
dea	11. Marital Status	3	12. Was Dece Armed Fo	edent Evar in U,S.	? If Yes, specify			lispanic Orig	in? (Sp	pecify Yas or No-	- 14. Ra	ace - Amaric		n,
72 hours efter death with the Maryland natural; or terms 23s or 28s-f show seal Exercises from the rottled a	1 ☐ Nevar Ma 3 ☐ Widowad	Married 2√2 Married 1√2 Yas If Yes, Gi Yaar or D		□ No							Spec		White	
natural',	(Sp	15. Decedent's ecify only highast of	Education greda complated)	ada complated) Giva kind of wor					of wor	king	16b. Kind of			o.f
Mental Hygiene metter other than "natura metic event, the Medical To Be Completed	Elementary/Se		life DO NOT use retired)								Department of			
	17 Father's Nam	a (First, Middle, La	st)	4 1	Loan Process				r's Nam	na (First, Middla,				
	Anthor		Schwart	z	Helen					Schew				
d 2 sl th and 7 ls n traur	19a. Informant's Name/Relationship (Type, Print)  Bernadette T. Schwartz (wife)  19b. Mailing Addrass (Street and Number or Rural Routa Number, City same as #10										er, City or Tow	n, Stata, Zip	Code)	
T E S	20a. Mathod of D	risposition		20b. Place	of Dispo	sition (Nam	a of		1	Data	20c. Location	- City or To	own, Stat	е
00		2 Cramation 3			natory or of		3/2000	Braddo	ock . Pe	nnst	vlvania			
permit. Pages Department of Important: If it any Injury or o		Fune al Service Lie		Monongahela Cemetery 11/13/2000 Bi										
The Dep	M	Sunn	Mar	chear	4	400 Pc	wde	er Mil	1 R	d. Belts	sville,	Mary	1and	
Physician	23a. Part1. Enta shock, or he	r the disaasa, or co east failure. List on	mplications that only one cause on a	aused tha daath. Do ach line.	not en	ter the mode	of dyir	ng, such as	cardiec	or respiratory a	rrast,		Approxi Intarval Onsat a	imata I Batween and Death
/Medical Examiner	Immedieta Ceus disaasa or condi rasulting in daath	tion	a. My	cardia	1 3	In fave	tio	h					hove	-5
je je				Due to (or as	a consec	quence of):								
be executed sicien and buriel-transit	Sequantially list	conditions,	b	Dua to (or as	a consac	quance of):								
ien a	Sequantially list if any, laading to cause. Entar Un Cause (Disaasa	immadiate darlying or injury										1		
physicies the burner of the	that initiated ever	nts 👚	G	Dua to (or as a	consec	juance of):								
attending p for use es			d									1		
death d for u	Part II Other ofor	nificant conditions	contributing to de	aath but not rasulting	In the	ndarlying of	use oi	ven in Part I		23b Did	tobacco use o	ontribute to	o the cer	use of death?
that the de ed by the detached Physic					III tila u	ridanying ca	usa gr	ven in rait i			Yes 2 No			4 Unknow
	,	Hypertension									an autopsy ormed?	av	allabla p	psy findings rior to n of causa
requires		1-1/0-1										of	death?	
The lew requires that the death certificate be executed the hes been signed by the attending physician and page 2 should be detached for use as the buriel-transicompleted by Physician/Medical Exami		19/200								100	Vae all Na	4.5		2 MINO
								29 Dinon	of De	1) (Check only		1[		3) No
Physician: The lew requires this certificate has been sig rel director, page 2 should b : To Be Completed b	25. Was case ref axaminar?	ferrad to medical	Hospital	Inpatiant 2 ER/	Butnatio	nt 35(DO	Ott	hor		ath (Check only o	ona)		☐ Yes	200 No

To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Division

1 Natural 2 Accidant (Month, Day Year) Work? 1 ☐ Yas 2 ☐ No 5 Pending investigation 6 Could not be determined 3 Suicide 28a Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 Homicida

29a. Cartifier (Check only one) 29b. Signetura and titla of certifiar

Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data and placa, and due to tha causa(s) and manner as steled.

| Madical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and due to the causa(s) and manner stated.

29c. Licansa number 047791

29d. Date signed (Month, Day, Year)

NOVEMBER 2, 2000

30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

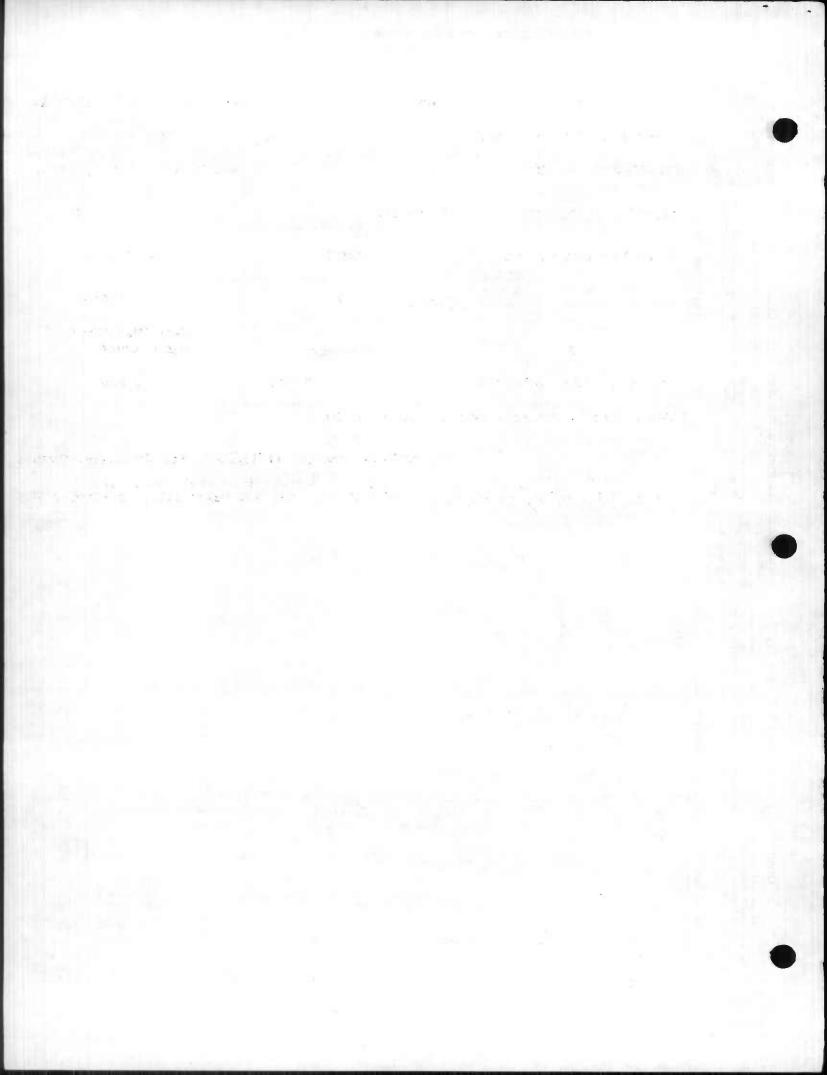
809 Veirs Mill Rd Rokville MD 20851 Pavid A Holden ms 31. Data filed (Month, Day, Year)

State Registrar

Certification

Medicai

32 Ragistrar's Signatura NOV 0 9 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** PAULINE NOVEMBER 4, 2000 U. 6:10 PM SHIPLEY /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner **MONTGOMERY** HIGHLAND AVENUE GAITHERSBURG If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) Nov. 6,1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthdey) 6 Sex **Funeral** Days 1 □ M 2 1 F Months VIRGINIA 74 Yrs. 218 24 2842 Director Usuel Residence of Decedent the Marylend 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits r 28a-1 show MD MONTGOMERY GAITHERSBURG 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filled within 72 hours effer deeth with it. Department of Health and Mentel Hygiene. Introprent: If them 27 is marked other than "neturel", or items 23a or 2, any injury or other traumatic event, the Wedgell Exempter 2007. 20877 UNITED STATES 5 HIGHLAND AVENUE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic OrlgIn? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) **FOGLESONG** DAVID UMBARGER JOSEPHINE 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 9434 TANEY ROAD, MANASSAS, VA. 20110 MITZI C. MENDOZA, DAUGHTER 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) JENNINGS CHAPEL CEMETERY 11/7/00 WOODBINE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME morey XI. Barker P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical Myo caula-Examiner Examiner physician and sthe buriel-transit nutersian requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 80 use 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 000 3 Probably 4 Unknown OSTO ANTHNIPS Records, by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed DENNESSION certificete has b RYPWY 1 ☐ Yes 2 No Sound B SO DAAGVAL Division of Vital 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: 5 Pending investigation or Attending 1 Naturel efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined n 24 hours efter des ne Funeral Director oletely filled in by the 3 Suicide 28e. Pleca of Injury - At home, farm, streef, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifier edicai 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end manner steted. (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier D33677 NOVEMBER 6,2000 20874 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) mo Ducrons Down 19530 EDWAND J Downo MD acremented of 31. Dete filed (Month, Day, Yeer) 32 Registrer's Signeture State

Registrar

NOV

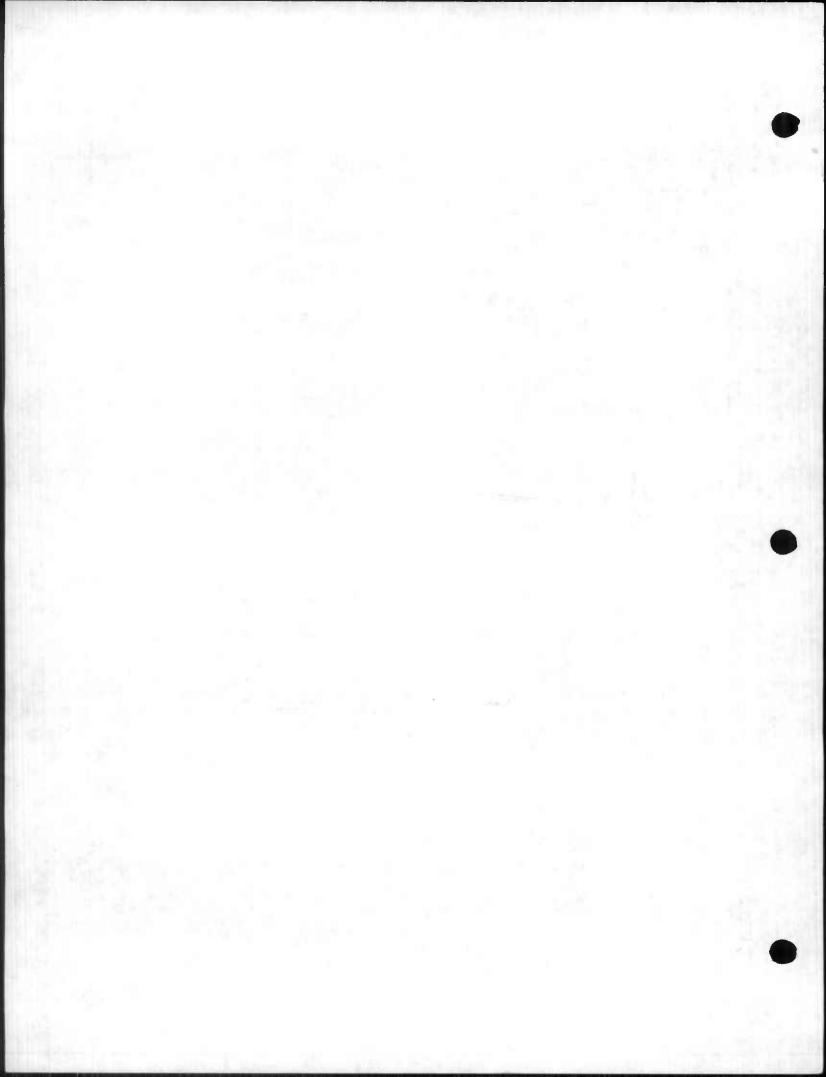
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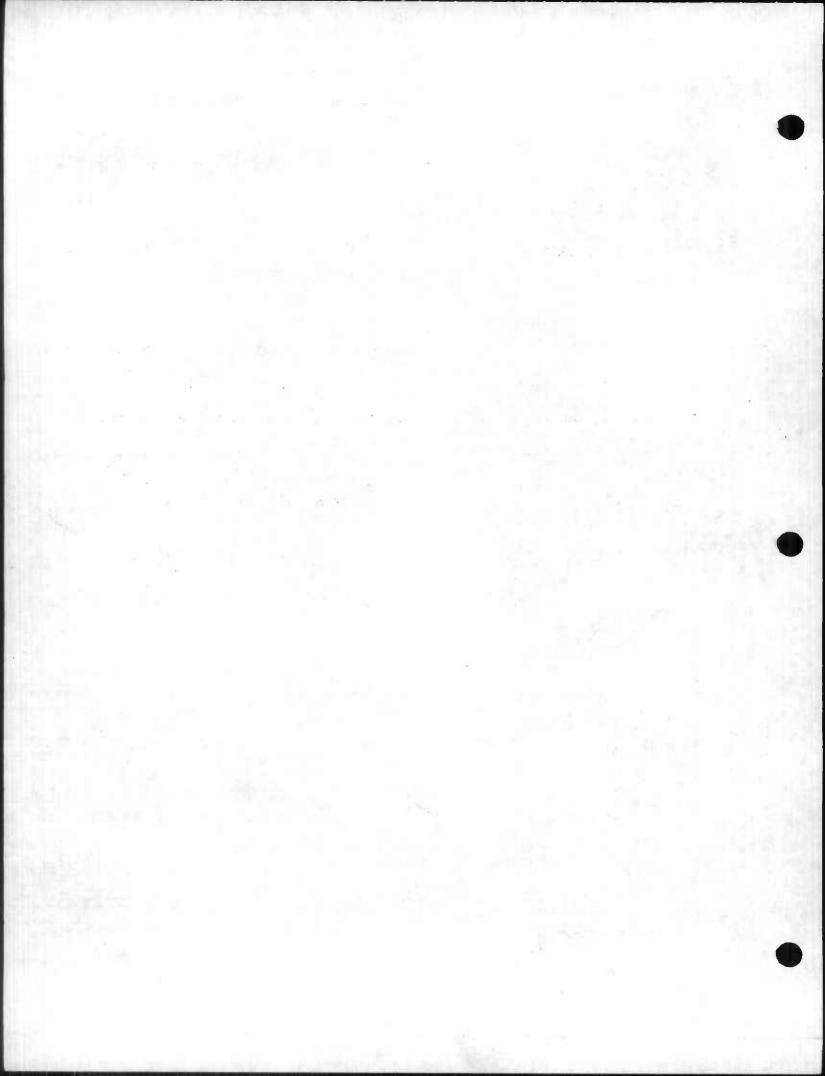
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				Cer	tificate o	t Death	7		Reg. No.	100		
	1. Decedent's Name (First, Middla,	Last)		M	110	100		2. Data of De Month		Veer	3. Time of Death	
Physician	Esther R. Schre	iner						Octobe	r 30°, 20	000	4:40 PM	
⊳/Medical Examiner	4a Facility Nama (If not institution,	give street and num.	ber)			4b. City, T	own, or L	ocation of Deatl	h 4c. County	of Death		
Zamino	15100 Interlach		Silv	er Si	pring	Montg	у					
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.								th	9. Birthp	lace (State or Foreign	
Director	117-18-5770	1□M 2⊠F	76	Yrs.	Months Day	's Hours	Min.	Aug. 17	7. 1924 I		York	
	Usual Residence of Decedent				1			1-0				
Car a Ma	10a. Stete 10b. County		10c. City, Tow	n or Loc	ation		1			1	0d. Inside City Limits	
Maryia -f show fled.at	MD Montgo	merv	Silv	er S	pring						1 ☐ Yes 21 No	
with the Marylanx a or 28a-f show be notified at Director	10e. Street and Number			10f. Zip Code					10g. Citizen of	What Cour	ntry?	
23a or 121 or 121 or 121 Or	15100 Interlach	on Dr #	407	20906						USA		
for death of the form the form the form the form for the form the	13100 IIICETTACII		lenf Evar in U.S.						- 14. Rac	ce - Americ	can Indian.	
Der o	1 Never Married 2 Marrie	Armed Ford	es?	in U,S. 13. Wes Decedent of Hispanic Origin? (Sp. If Yas, specify Cuban, Mexican, Puerto					Bla	ck, White,		
DZO	3 Widowed 4 Divorced	1	☐ Yes 2 N	lo Specify	<i>'</i> :		Specif	y:	White			
Pour hour	15. Decedent's	Year or Dat		Deced	ent's Usual Occ	unetion			16b. Kind of B	usiness/In	dustry	
1 21215-0 ad within 72 ho sygiene. ser than "natur it, the Medical.	(Specify only highest	grade complated)		(Give kind of work done during mo life. DO NOT use retired)			st of work	ing	100: 14:10 0: 0			
The state of	Elementery/Secondery (0-12)	College (1-	4or 5+)	Teacher					Pub1	ic Sc	hoo1	
Co of Bar	17. Father's Neme (First, Middle, La	4			Teach		ar's Nam	e (First Middle	, Maiden Sumar		11001	
every Be	Wolf Cohen	131)						Tartak	,	,		
To			1		4.11				O' T-	Charles Tie	0-4-1	
Maryland 21215-0020 td 2 should be filed within 72 hours at the and Mental Hygiene. The surrised other than "natural", or traumatic event, the Medical Exam	19a. Informant's Name/Relationshi								er, City or Town			
e, R Health em 27 ther tr	Helene Carol Br	aun/ daug					ка.,	-	Spring			
10 10 10	20e. Method of Disposition  1  Burial 2  Cremetion 3	☑Removel from S	tate 200. Place o	ry, crem	ition (Name of atory or other p	olace)	N	Dete	20c. Location	- City or To	own, State	
altimore, mil. Pages 1 ar partment of Hea portant. If Hem 3 y Injury or other S8.	4 Donation 5 Other (Spe			Par	k Cemet	ery	1	2000	Paramu	s, NJ	ī	
S Track	21. Signature Funeral Service Licensee  22. Nama and Address of Facility Danzansky-Goldberg Memorial Chapels, 1170 Rockville Pike, Rockville, MD 20											
m sales												
	23a. Part 1. Enter the disease, or o	omplications that ca	usad the death. Do							D 200	Approximete	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	a/	Metasta  Due to (or as e			of Co	lon			1	1988	
OX OS / OU, certificate be executed ding physician and itse as the bunial-transit	Sequentietly list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Disease or injury that initiated events resulting in deeth) Last	c	Due to (or as e									
dS, F.O. BOX of irres thet the death certiful signed by the attending does be detached for use and by Physician/Mc												
the de sched	Part If. Other significant condition	contributing to dea	th but not resulting i	in the un	derlying cause	given in Perl	11.	23b. Did	tobacco uss co		o the cause of death	
T de go E								10	Yss 2X No	3 Pro	bably 4 Unknow	
Hecords, he law requires th s has been signe tge 2 should be d									all-lassane.	045 141	ere autopsy findings	
The law requires The law been sign page 2 should be Completed by	20075								an autopsy ormed?	av	aitable prior to	
law							_			of	death?	
								10	Yes 21 No	11	☐ Yes 2☐ No	
otor, I	25. Was case refarred to medical					26. Pta	ce of Dea	th (Check only	one)			
Of Vita Physician: this certific ral director,	examiner? 1 ☐ Yes 2 ☑ No	Hospitel:	patient 2 ER/O	utpatient	3□ DOA	Othor:			idence 6 Ott	her (Speci	(v)	
Phys rithis aral di	27. Manner of Death	28e. Dete of		Time of		njury at Vork?			how Injury occu		,,	
DIVISION Of VITAL  or Attending Physician: The after death.  Director: After this certificate in by the funeral director, partification: To Be Co	1 ☑ Neturet 5 ☐ Pending 2 ☐ Accident Investiga		, Day Year)	Injury		Vork? ☐ Yes 2[	No					
des ctor of the y the	3 Suicide 6 Could no	t be 28e. Plece o	of tnjury - At home, fe	erm, stre	et, fectory, offic	20		28f. Location	Street and Num	ber or Run	al Routa Number,	
ert ert	4 Homicide	buildin	g, etc. (Specify)			XH		City or To	wn, Stete)			
portal portal C	29a. Certifier 11X Certifying	Ohusiaian: To the h	ant of my knowledge	o dooth	popured at the	timo dato o	nd place	and due to the	ceuco(c) and m	00001001	stated	
DIVISION Control to the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:			sest of my knowledge sis of examinetion are stated									
He Hin S	29b. Signatura and title of cartifiar	and menin	ar stered.		29c Lice	ensa number			29d. Date signs	ed /Month	Day Year)	
	23b. Signatura and little of cartinal	#	A) th			7158			4			
10	Kernel	( C=	WILL	_					Nov. 1,	200	00	
	30. Nema and address of person wi											
	Kenneth Goldst	ein, 214	1 "K" St.	NW .	Washi	ngton,	DC	20037				
State	31. Deta filed (Month, Dey, Year)	32. Ré	gistrar's Signature	1.	- 1				7			
Registrar	NOV 06	2000	year ,	Ø.	Spark	2						



State of Maryland / Department of Health and Mental Hygiene

				Certificate d	of Death		leg. No.	31	181
Physician	Decedent's Name (First, Middle, L.  John	.ast)	5	Seifert, Sr.		2. Date of Dea		Year	3. Time of Death 9:43P
/Medical	4a Facility Name (If not institution, g	ive street and number)				Location of Death	4c. County o	f Death	
Examiner	Laurel Regional Hos				Laurel			ce Geo	roe's
Funeral Director			e (In yrs. last birth 83 Y		per If Under 24 Hi			9. Birthple	New York
	Usual Residence of Decedent								
or 28a-f show or 28a-f show north of the	Maryland Prince	George's	Beltsv					10	d. Inside City Limits  1 Yes 2 No
15 w th w	10e. Street and Number 3205 Dunnington	Road		10f. Zip Coo 2070		1	United		
To the Pe	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1  Yes 2 H If Yes, Give X Yeer or Detes:		13. Was Decedent tf Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pue No Specify:	(Specify Yes or No- irto Rican, etc.)	Black	- America , White, e Whi	tc.
	15. Decedent's (Specify only highest of		16a. I	Decedent's Usual Oc 'Give kind of work do	ccupation one during most of w tired)	orkina	16b. Kind of Bus	iness/Indu	ustry
d within giene. r then the the	Elementary/Secondary (0-12)	College (1-4or 5	4.1		ector/Deal		Automob	ile i	Industry
Hygien Hygien Her th	17. Father's Name (First, Middle, Las		Z Sei	.VICE DII		ame (First, Middle,			Industry
inould be filed in Mentel Hyginarked other metic avent, To Be Co	William Arthur					Thurston	Walder Surreme	"	
2 4 5	19a. informant's Name/Relationship William A. Seif	(Type, Print)			reet end Number or 1				
emit. Pages 1 and j Pepartment of Health Important: if New 27 in y Injury or other tr	20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removel from Stete	20b. Place of I	Disposition (Name of cremetory or other	1	Date	20c. Location - C	City or Tow	vn, State
pemit. Page Department of Important: If any injury or phos.	21. Signeture of Funeral Service Lic	Brown		Donald V	der Mill	it Funera Rd. Belts	1 Home, ville, M	P.A.	and 20705
rificate be executed no physician and set the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ChRono	Due to (or as a co	RueTivE onsequence of):		ary Di		6	
attending for use		d							
at the death  by the attendached for u	Part II. Other algnificant conditions	contributing to death b	ut not resulting in	the underlying caus	given in Pert I.	23b. Did t	obaceo use con	tribute to	the cause of death
that the death celed to by the attendir detached for use	HYPERTEN	Sign				101	708 2□No	3 Prob	ably 4 ☐ Unknow
requires heen sign hould be	THYROID	CANCE	R		Least.	24a. Was a	an autopsy med?	ava	re eutopsy findings ilable prior to apletion of cause
ne law s has t ige 2 s	(					101	0000		léeth? I Yes 2□ No
yalclen: The li ls certificate he director, page To Be Com	25. Was case referred to medical				OG Pleas of F	leath (Check only o	1	10	1198 2LINO
Physicien: The certificate rai director, per To Be Co	examiner?	Hospitel:	ent 2 DER/Out	patient 3 DOA	Other	Home 5 Resid		r (Specify	)
£ 5 8	27. Manner of Death  1	28a. Dete of Inju (Month, De	the second second		Injury at Work?		ow injury occurre		
To the Hospital or Attending Ph within 24 hours after death To the Funeral Director: After thi completaly filled in by the funeral Medical Certification:	3 Suicide 6 Could not determine		ury - At home, fan c. (Specify)	m, street, factory, of	lice	28f. Location (S City or Tow	Street and Numbern, Stete)	or Rurel	Route Number,
he Hospital in 24 hours he Funeral pletsly filled edical C		Physician: To the best of aminer: On the basis of end manner sto	examinetion and						
within 2 To the comple	29b. Signature and title of certified	1		29c. Li	cense number		29d. Date signed	(Month, E	Day, Year)
112	1 tu, /_	tane ,	nn	Dog	2284	C	11/0	6/0	D
	30. Name and address of person wh	o completed cause of d	leath (Item 23a) (T		lazel Tape.	PRING	, mp	20	904
State	31. Date filed (Month, Day, Year)	32. Begistr	ar's Signeture	1 /	1	0	1		1

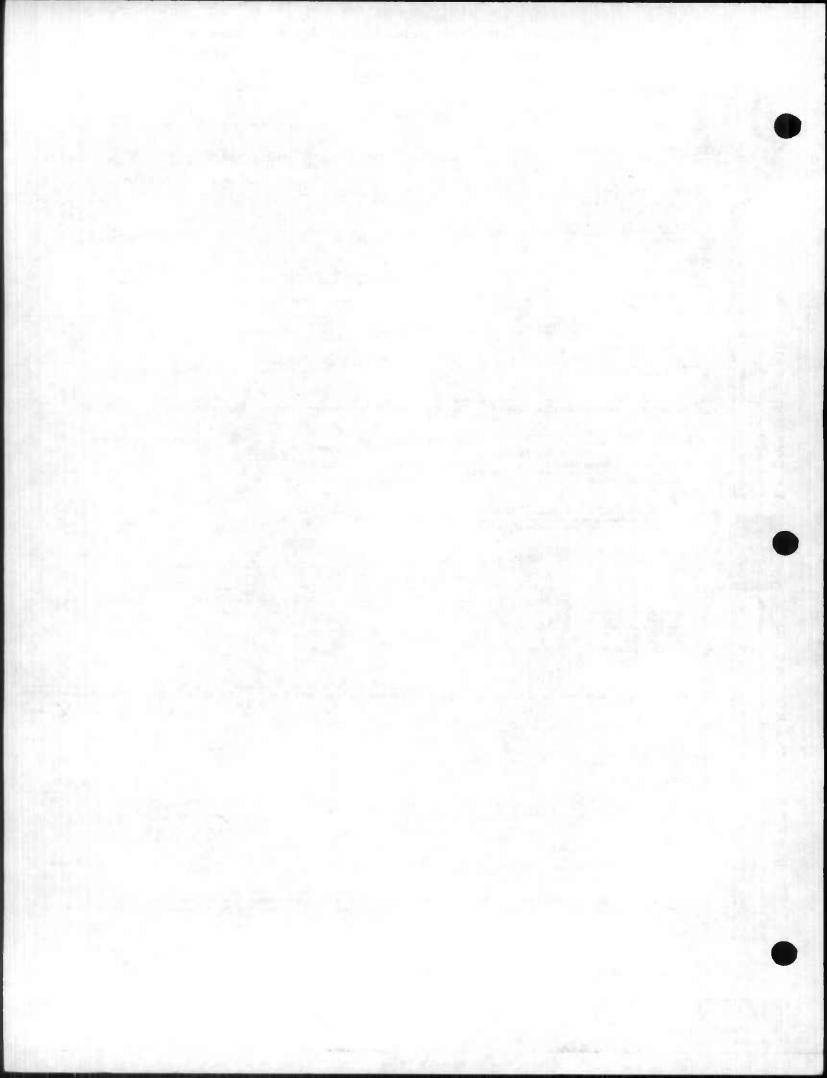


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3 Time of Death Month 004 MA **Physician** 6 2 /Medical 4b. City, Town, or Location of Deeth 4e Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner 20535 Summer Song Lane Germantown
| Mundar | Yaer | Munder 24 Hrs. | 8
| Months | Days | Hours | Min. | Montgomery Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Yrs 52 214-52-4376 Director Apr 1, Maryland Usual Rasidence of Decedant filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Insida City Limits 10b. County permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylar Department of Heelth and Mental Hygiens. Important: if item 27 in marked other than "natural", or itema 23s or 28s-1 show with injury or other treamble event, the Medical Examiner must be notified an once. 28a-1 show 1 Yes 2 No **Funeral Director** Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 USA 20535 Summer Song Lane 12. Wes Decadent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yas, Giva 14. Raca - Amarican Indien, Black, White, etc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Maritai Status 1₺ Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: White Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Electronic Data Elementary/Secondary (0-12) College (1-4or 5+) Systems Contracts Negotiator 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Earl S. Semler Mary E. Fowler 19a, informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mary E. Semler / Mother 20874 20535 Summer Song Lane, Germantown, MD 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Deta 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removel from Stata 11/7/00 Alexandria, VA 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 21. Signature of Funarai Sarvice Licensee 22, Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata intarval Batween Onset and Death **Physician** /Medical Purchio Vanculor immediata Causa (Final disaasa or condition resulting in death) Examiner Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Disease or injury that initiated events rasulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consequanca of) detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? beo, tu No No 1 Yas 1 Yas 2 No 25. Was casa rafarred to medical exagniner? 26. Place of Death (Check only one) Hospital: 1 inpatiant 2 ER/Outpatient 3 DOA 1 X Yes Othar: 4 Nursing Homa Medicai Certification: To 2 No 5 Aesidenca 6 Othar (Specify) this Mannar of Death 28d. Describe how injury occurred 28c. tnjury at Work? 28b. Tima of After 5 Panding after death. Director: Aft 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide Hospital within 24 hours To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and mannar stated To the 29d. Dete signed (Month, Day, Year) 29c. Licansa number 29b. Signeture and titla of certifie 10 30. Nama and addrass of person who complated causa of death (itam 23a) (Type, Print) Blvd = 220 Rodbulle U01 1100x 31. Data filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Day Month Year **Physician** Robert Shibler Nov. 6, 2000 8:30AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Haven Home Mt. Airy Carroll 8. Date of Birth (Month, Dev. Year) April 18, 1916 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Months 12 M 2□ F Hours 213-16-2826 84 Yrs Pennsylvania Director Usual Residence of Decedent the Manyand 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ethan "natural", or lears 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 No Maryland Montgomery Rockville Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1113 Clagett Drive 20851 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status hours after 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ™ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important if Item 27 is marked other than "nat any injury or other traumatic event, the Medica 2008. 77 Elementary/Secondary (0-12) College (1-4or 5+) Fire Department Captain 11 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Earl Lawrence Shibler Nora Conn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dean E. Shibler/Grandson 1113 Clagett Drive, Rockville, Maryland 20851 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete November Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 7,2000 21. Signature of Funeral Service Licensee

Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850–2805

23a. Partl. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final Alzheimer's Disease diseese or conditi-resulting in death) Examiner Due to (or as e consequence of): Examine Ventricular Fibrillation ed by the attending physician and detached for use as the burial-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thef initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o signed by t 1 Yes 210No 3 Probably 4 Unknown ۵. requires that Records, þ 24b. Were eutopsy findings available prior to been si Completed 24a. Was an autopsy completion of cause of deeth? aw. After this certificate has page 2 The 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital al or Attending Physician; Ts after death.

I Director: After this certifical of in by the funeral director, p 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury et Work? Certification: Division 5 Pending Investigation 1 X Natural 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital of To the Hospital

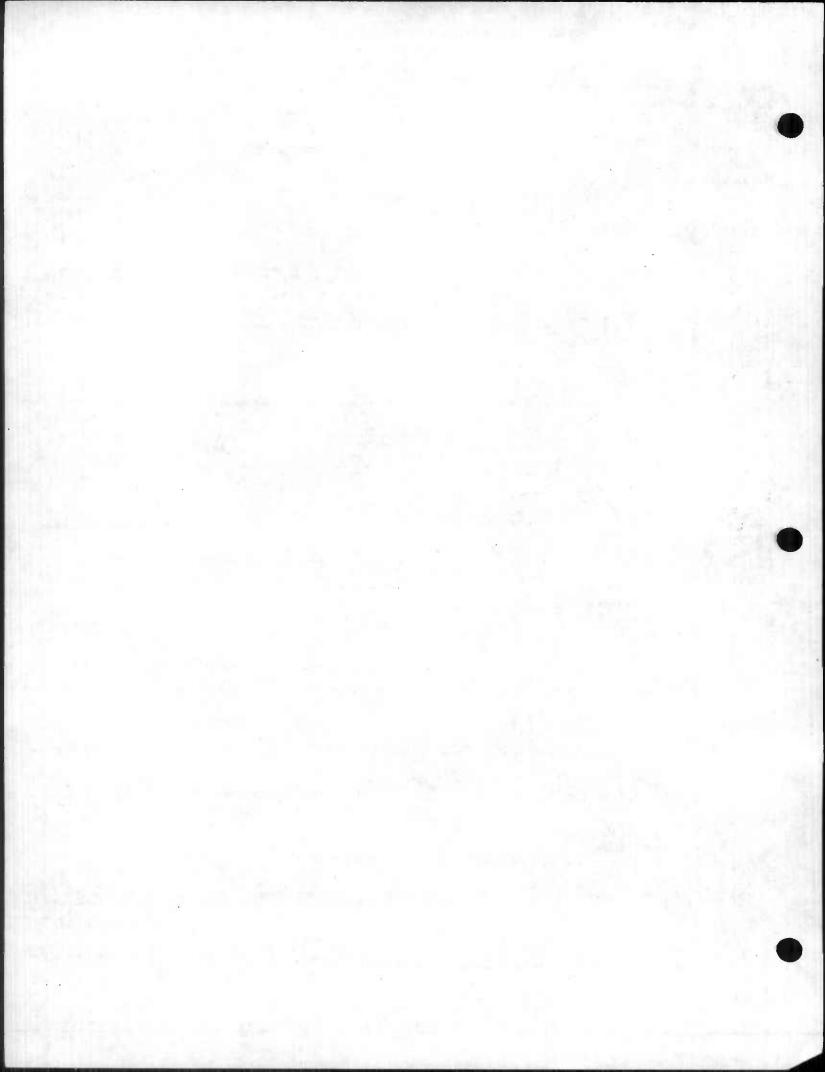
within 24 hours a

To the Funeral C

completely filled edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier + H51280 15 November 6, 2000 los: 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar, DO, 13219 Executive Park Terrace, Germantown, Maryland 20874

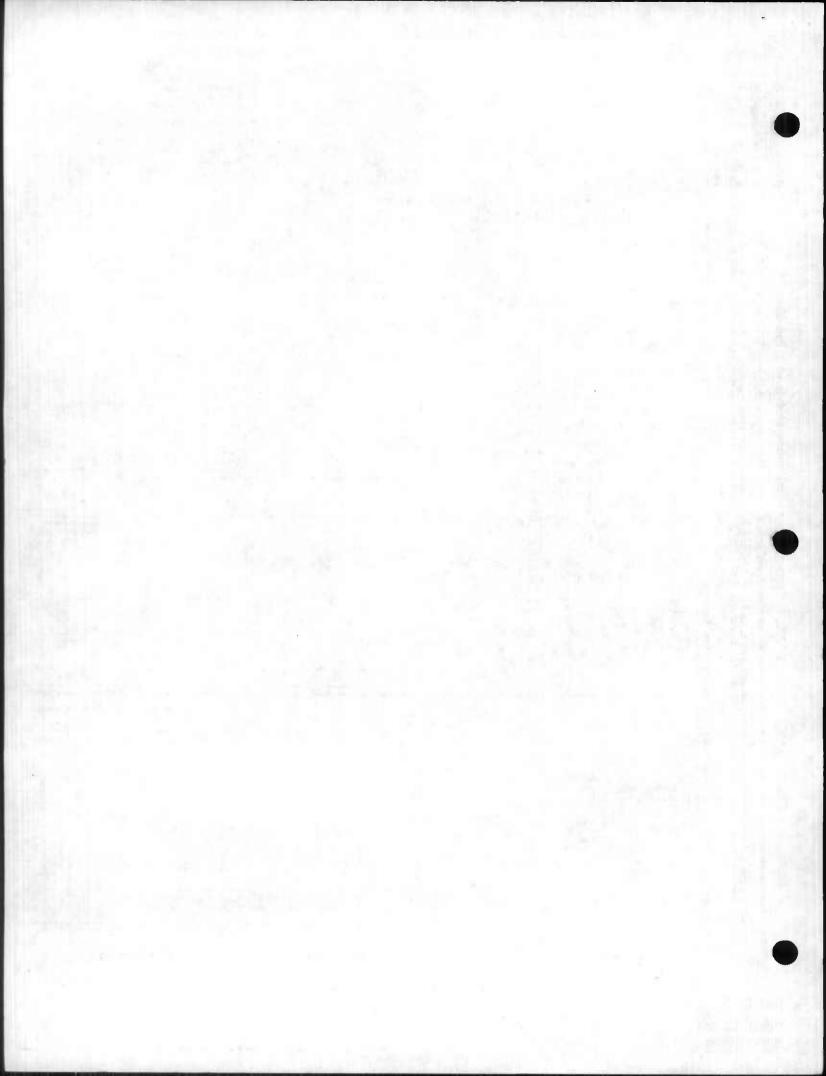
State Registrar 31. Date filed (Month, Day, Year) 08 2000 32. Registrer's Signeture Scherce

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	18,11/9/2000, BMW, 1. Decedent's Name (First, Middle,			3011		of Death	2. Date of De			3. Time of Death			
an al	INNIS R. S	KINNER Jr.					Novemi	per 5, 2	000	5:40 am			
er	4a Facility Neme (If not institution,	give street and number)				4b. City, Town, or	Location of Dea	h 4c. County	of Deeth				
	Casey House				Williams	Rocky		Mont	gomer				
	The second secon	Sex 7. Ag	ge (In yrs. le 80	st birthday) Yrs.	Months De	eer If Under 24 Hr. eys Hours Mir	(Month, D	ay, Year)	9. Birthp	elece (Stete or Foreign			
	577-14-0871	X 231	00	Yrs.			Dec.	, 1919	Wash	ington D.C			
-	Usual Residence of Decedent  10e. State 10b. County		10c. City	Town or Loc	ation				1	0d. Inside City Limits			
	Md. Montgo	marv		ithers						1 X Yes 2 □ No			
	10e. Street and Number	mery	Ga	Luiersi	10f. Zip Coo	lo.		10g. Citizen of \	What Coun	atru?			
ı		#201											
ŀ	403 Russell Ave	12. Was Decedent	Ever in 11 9	12 W		20877	Specify Ves or N	United States 14. Rece - American Ind					
ŀ	11. Meritel Status  1 ☐ Never Married 2 ☑ Merrie	Armed Forces?	No		Yes, specify (	of Hispanic Origin? ( Cuban, Mexican, Pue	rto Rican, etc.)	Blac	Black, White, etc.				
	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	194		☐ Yes 2🂢	No Specify:		Specify: White					
	15. Decedent's		194		ent's Usuei Oc	cupation	16b. Kind of Busines			dustor			
	(Specify only highest	grade completed)		(Give k	ind of work do	one during most of wa	working			200119			
	Elementary/Secondary (0-12)	College (1-4or	5+)			Officer	Navy Dena			ment			
ŀ	17. Father's Neme (First, Middle, La	est)		Trocar	rment (		me (First, Middle	Navy Department  (First, Middle, Maiden Sumame)					
	Innis R. Skinr					Celes	tia Sou	ders					
ł	19e. Informent's Name/Reletionship			19h Mailing	Address (St			or, City or Town, Stete, Zip Code)					
	Lydia B. Skinne					ussell Ave #201 Gaithersburg							
1	20e. Method of Disposition	- (	20b. Pl		Date	20c. Location -							
	1 ☑ Buriel 2 ☐ Cremetion 3	Removal from State	Ce	metery, cremi	etory or other	plece)	Nov.8.	Falls (					
Amplus 21.	4 Donetion 5 Other (Specify)  National Memorial Park 2000 Falls  21. Signeture of Funeral Service Licenses  22. Name and Address of Facility DeVol Funeral Ho										n, va.		
	21. Signeture of Funerel Service Li	censor		22.	Name end A	ddress of Fecility D	eVol Fun	eral Hon	ne				
	23a. Part1. Enter the disease, or complications/that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, and interval Bet interval Bet interval.												
Examiner	resulting In death)	b	Due to (or	es a consequ	ienca of):				1				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or Injury c.									1				
	Cause Disease of Injury that initiated events resulting in deeth) Last  Due to (or es e consequence of):												
	Part II. Other significant condition	contributing to death b	out not resu	lting in the und	derlying cause	given in Part I.	23b. Dic	tobacco use co	ontribute to	o the cause of death?			
l							1	Yes 2X No	3 Pro	bably 4 Unknown			
1							-	-110	T 0.45 W/	and a state of the state of			
1							24e. Wa	s an eutopsy ormed?	av	ere eutopsy findings allable prior to empletion of cause			
									of	death?			
							1	Yes 2∑No	1[	Yes 2□ No			
	25. Was case referred to medical					26. Place of D	eeth (Check only	one)	26. Place of Deeth (Check only one)  3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospi				
	exeminer? 1 ☐ Yes 2 ☒ No	Hospitel: 1  Inpati	ent 2□E	R/Outpatient		Other: 4 Nursing			her (Specif	W Hospice			
	exeminer? 1 Yes 2 No 27. Manner of Deeth	1 L Inpati		28b. Time of			Home 5□Res			W Hospice			
	exeminer?  1 Yes 2 XNo  27. Manner of Deeth 1 XNatural 5 Pending investiga	28e. Date of Inju			28c.	Other: 4 Nursing	Home 5□Res	idence 6 XIOtt		W Hospice			
	exeminer?  1 Yes 2 No  27. Manner of Deeth 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could mis	28e. Date of Inju (Month, De	iry by Year) jury - At hor	28b. Time of Injury	28c.	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home 5 Res 28d. Describe	how injury occur	rred	Mospice Mai Route Number,			
	exeminer?  1 Yes 2 No  27. Manner of Deeth  1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no	28e. Date of Inju (Month, De	ary by Year)	28b. Time of Injury	28c.	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home 5 Res 28d. Describe	how injury occur	rred				
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 2000 7, Month NOV. E. SMITH 7:14 AM GEORGE 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Beltsville PRINCE GEORGES 7821 Muirkirk Road | Words | Win. | 8. Dete of Birth (Month, Day, Year) | July 28,1916 If Under 1 Year Months Days 5. Social Security Number 7. Age (to vrs. last birthday) Birthplace (Stete or Foreign Country) Days 12 M 2 F 84 Yrs. Maryland 579-18-5708 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 11 Yes 2 No Prince Geo. Beltsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7821 Muirkirk Road 20705 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 120 Yes 2 □ No If Yes, Give Year or Detes: 43-46 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status 1 Never Merried 2 Married Black 1 Yes 20No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) U.S.D.A. 7th Custodian/Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) George E. Smith, Sr. Mary Etta Brewer 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7821 Muirkirk Road, Beltsville, MD 20705 Madeline V. Smith (Wife) 20b. Piece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 Cremetion 3 Removel from Stete Nat'l Mem. Park 11/10/00 4 □ Donetion 5 □ Other (Specify) Laurel, MD 21. Signature of Funeral Service License 22. Name and Address of Fecility SNOWDEN FUNERAL HOME, P.A. St., Rockville, MD 20850 246 N. Wash. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final months disease or condition resulting in death) cancer Due to (or es a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 21 No 3 Probably 4 Unknown lubular aderoma 24b. Were eutopsy findings available prior to 24a. Wes en autopsy performed? perterscompletion of cause of death? 1 Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one)

**Physician** /Medical Examine

that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

Attending

this

**Physician** 

/Medical

Examiner

10e Stete

**Funeral** 

Director

28a-f ahon

6

Items 23s

ifiled within 72 hours after de l'Hygiene. Other than "natural", or item

Pages 1 and 2 should be filed nent of Health and Mental Hygi mt: If Nem 27 Is marked other

permit. Pages 1 end 2 s Depertment of Health er Important: if item 27 is any injury or other trau once.

Baltimore, Maryland 21215-0020

Director

by

Completed

Be

the Maryland

Examine physician and the burial-transit use signed b certificate To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fun

Physician/Medicai P Completed Be 0 Certification:

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth

> 1 Meturet 5 Pending Investigation 2 ☐ Accident 3 ☐ Suicide 4 Homictde

6 Could not be

28a. Dete of Injury (Month, Day Year) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

Hospitet:

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 28c. Injury at Work?

1 TYes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature end title of certifier gela

29a. Certifier (Check only one)

2 nearly

29c. License number D43575 29d. Date signed (Month, Day, Year) 11-67-00

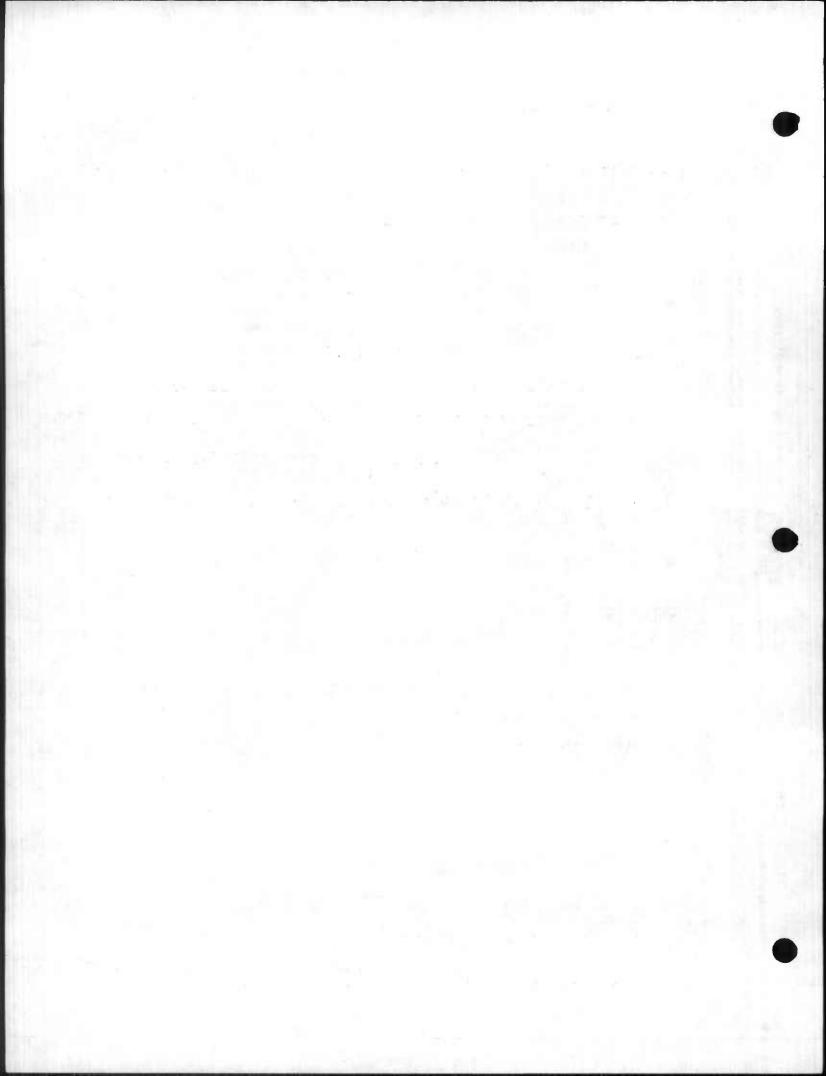
DUSEN RD, SUITE 130 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7355 , ND. ANGELA DUNCAN LAUREL. 20707 MD

State Registrar

Medical

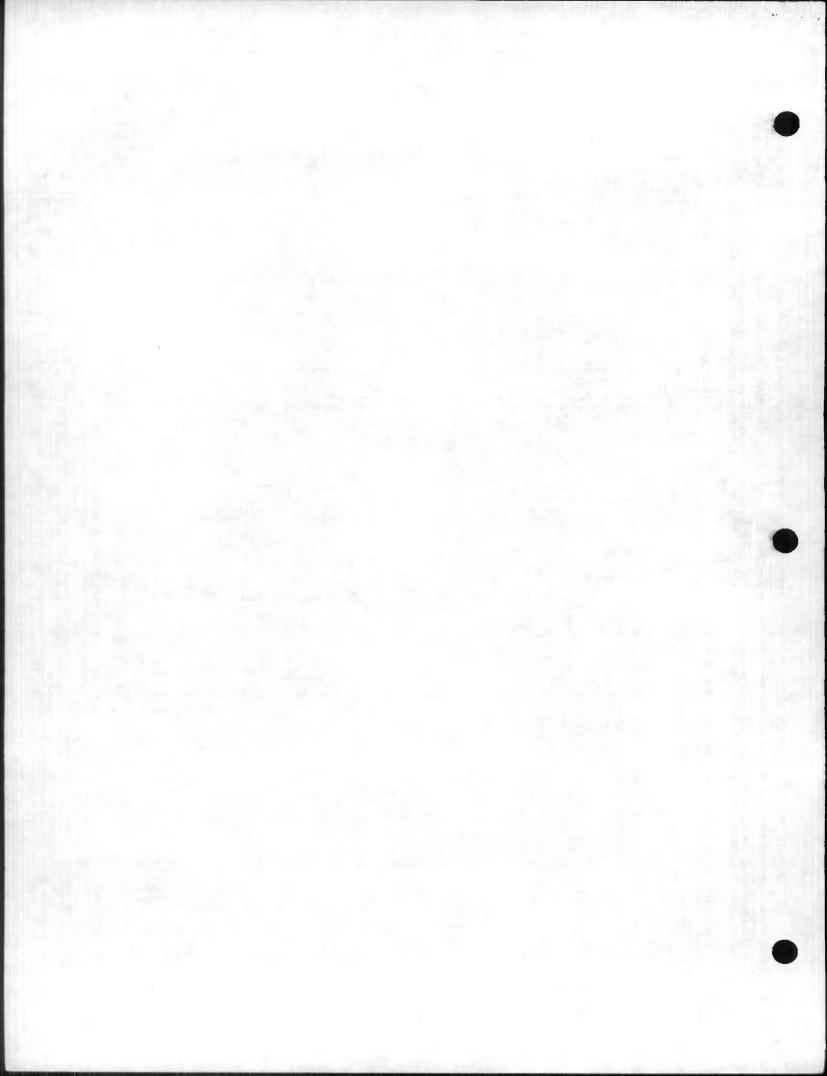
31. Dete filed (Month, Dey, Year) NOV 0 9 2000 32. Registrer's Signeture

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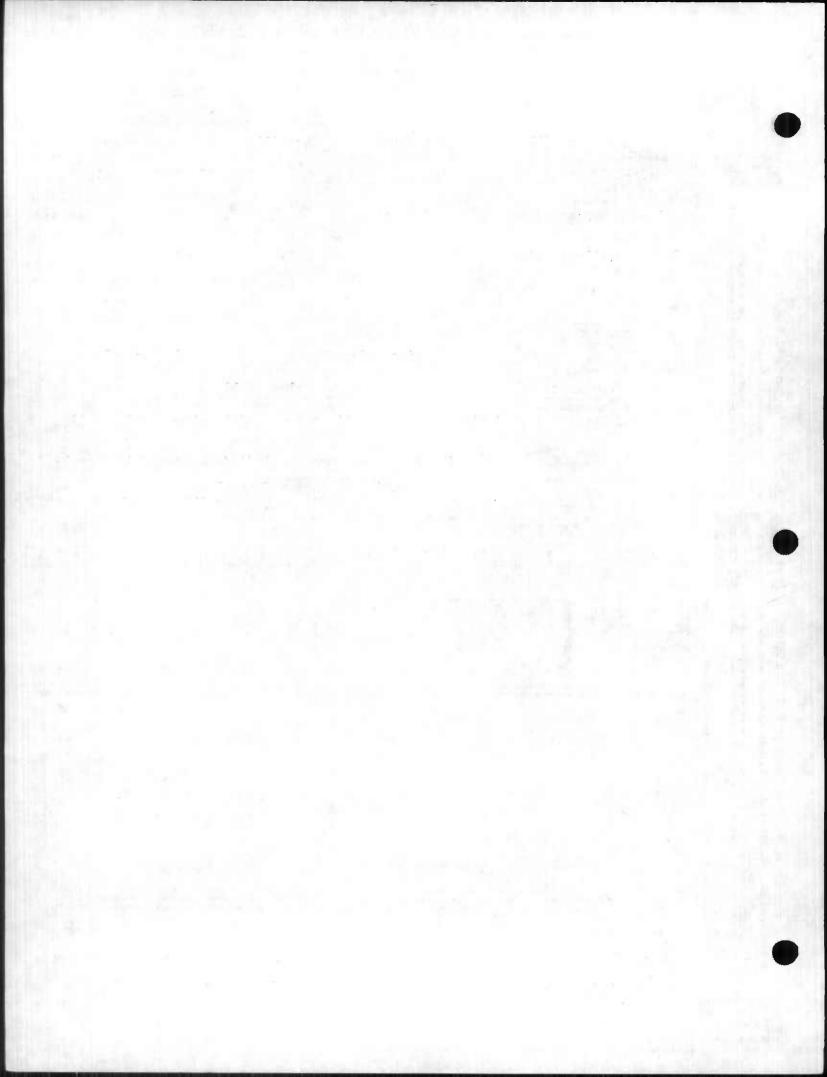
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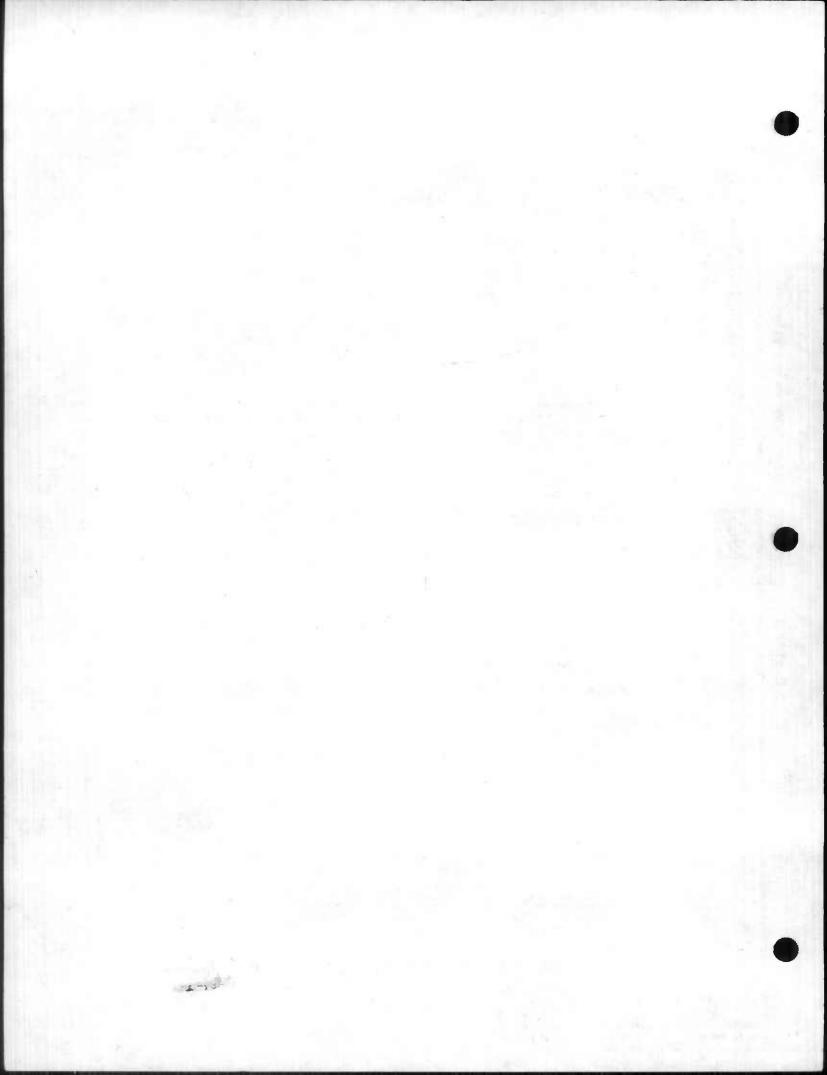
State of Maryland / Department of Health and Mental Hygiene 37187

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Elementery/Secondery (0-12) 12 Fether's Neme (First, Middle, Last) Harry Starkweath De Informant's Neme/Relationship (Ty) Donna W. Starkwea	Cotlege (1-4or 5+)	life. L	kind of wo	el Occupe	ation Jurina most of wo	rkina	16b. Kind of Bu	usiness/In	dustry			
Fether's Neme (First, Middle, Last) Harry Starkweath De Informant's Neme/Relationship (Ty) Donna W. Starkwea			DO NOT U	ise retired)	luring most of wo							
Harry Starkweath De Informant's Neme/Relationship (Typ Donna W. Starkwea	er	Bioc	hemi	st			Bio-Te	chno	logy			
Donna W. Starkwea	er				18. Mother's Na	me (First, Middle	e, Meiden Sumem	10)				
Donna W. Starkwea					Helen	Kelly						
Donna W. Starkwea	oe. Print)	19b, Meilin	na Addres	s (Street e	and Number or R	urel Route Numi	ber, City or Town,	Stete, Zij	p Code)			
					na Dr.,			Md.	20879			
		. Place of Dispos				Dete	20c. Location -					
1 ☑ Buriel 2 ☐ Cremetion 3 ☐ R	emovel from State	cemetery, crem	netory or o	other place			1000					
4 ☐ Donefion 5 ☐ Other (Specify)	H	illcrest	: Mem	. Gar	dens 1	1/10/00	Annapo	lis,	Maryland			
. Signefure of Funeral Service License	10	M11	Name e	nd Addres	s of Fecility	unanal	Homo					
Muriel W.	Barker							ובלעמ	nd 20882			
3a. Pert 1. Enter the disease, or compli	cations thet caused the de							ylai	Approximete			
shock, or heart failure. List only on	e cause on each line.								Intervet Between Onser end Deeth			
nmadiata Causa (Final	Matacha	tio Mal		_				i.	15 months			
seese or condition	Metasta 	itic mei	anom	d					15 months			
outing in dooring	Due to	(or es e conseq	(uence of)	):				1				
equentially list conditions,	Due to	Due to (or as e consequenca of):										
use. Enter Underlying												
ef initiated events	Due to	:										
outing in double, East												
or II Other elanificant conditions con	tributing to death but not r	aculting in the ur	nderhina	cause cive	on in Part I	23b. Did tobacco use contribute to the cause						
at ii. Other arginineant conditions con	and any to death but not t	oscitally at the ut	nuonying (	annon Alae	O	1			obably 4 Unknow			
						1	J 105 2∐ NO	3   Pr	JOEDRY - (2) ORKNOW			
						240 14/0	on autonou	24h W	Vera eutopsy findings			
								8	vailable prior to completion of cause			
								0	f deeth?			
						10	Yes 25 No	1	☐Yes 2☐No			
			-		26. Place of De	eth (Check only	one)					
	lospitel:	□ ER/Outpetien	nt 3□ D	OA Othe	or:			er (Spec	Hospice			
	28e. Dete of tnjury	28b. Time of				,			HOSPICE			
1 Naturet 5 Pending	(Month, Dey Year,	Injury										
3 Suicide 6 Could not be	28e. Plece of Injury - A	home form str				28f Location	(Street and Numb	her or Ru	ral Route Number			
4 Homicide determined	building, etc. (Spe		eet, lector	ty, onice			own, Stete)	501 01 110.				
7	Iclan: To the best of my k											
	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the cause(s) end menner as 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pieca, end due end manner steted.								,			
(Check only 2 Medical Examir									, Dey, Year)			
(Check only 2 Medical Examir		29c. License number 29d. Date signed (i										
(Check only 2 Medical Examinations)		DOOS4378 NOVEMBER						200	2 5			
(Check only 2 Medical Examirons) b. Signeture and tills of certifier		lom 02-1 (T		005	1378			DEI	25,000			
(Check only 2 Medical Examinations)		tem 23a) (Type,	Print)	)005°		GTON, D	NOVER	807	25,600			
Ties	Asa. Pert1. Enter the disease, or complishock, or heart failure. List only on mmediate Cause (Finel isease or condition saulting in deeth)  dequentially list conditions, eny, leeding to immediate ause. Enter Underlying lease (Disease or Injury lef initiated events assulting in deeth) Last  det II. Other algnificant conditions conditions conditions.	shock, or heart failure. List only one cause on each line.  mediate Cause (Finel issess or condition asulting in deeth)  Due to b.  Due to b.  Due to b.  Due to c.   ### Part 1. Enter the disease, or complications that caused the deeth. Do not ent shock, or heart failure. List only one cause on each line.  #### Metastatic Mellisease or condition asulting in deeth)  #### Due to (or as a consect of the failure)  ###################################	P. O.	P. O. Box 5    Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.    Metastatic Melanoma	P. O. Box 5038, L  Base Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.  The decidence of the disease or condition as the cause of the deeth. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.  The decidence of the deeth of th	P. O. Box 5038, Laytonsv  P. O. Box 5038, La	Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Ma Sa. Pertl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.    Metastatic Melanoma   Due to (or as a consequence of):	P. O. Box 5038, Laytonsville, Marylan				



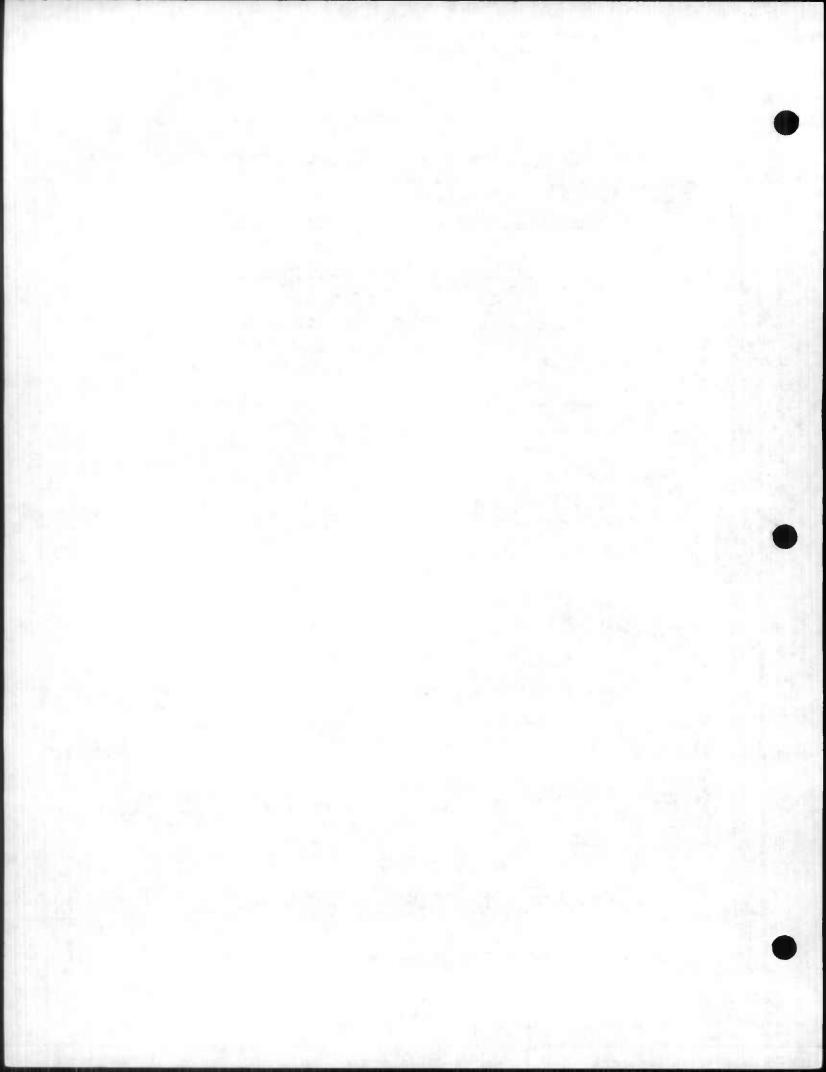
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middia, Last)	rtificate of Death	Reg. No.	3. Time of Death
Physician /Medical	Lillian Stein		Month Day	Year 2000 1/25m
Examiner	4e Facility Name (If not institution, give street end number) Hebrew Home of Greater Washington	4b. City, Town, or I Rockvil		ty of Death
Funeral Director	5. Social Security Number  163-07-3618  6. Sex 1 M 2 M F  7. Age (In yrs. last birthday) 90 Yrs.			9. Birthplace (Stata or Foraign Country) Pennsylvania
with the Maryland a or 28a-f show to notified a	Usuel Residence of Decedent         10e. Stete         10b. County         10c. City, Town or Lo           MD         Montgomery         Rockville			10d. Inside City Limits 1 ∑ Yes 2 □ No
Office death with the Mainter death with the Mainter 23st or 23st/s	10e. Street and Number 6105 Montrose RD	10f. Zip Code 20852	10g. Citizen of U.S	f What Country?
Dy by	1 Never Married 2 Married 1 Yas 2V No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.) 14. Re BI	ace - American Indian, leck, White, etc. ify: White
within then then then then then then then the	(Specify only highast grada completed) (Giva Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) Dkkeeper	king	Business/Industry mobile Dealershi
D #FFF O	17. Father's Name (First, Middle, Last) Benjamin Zorocoff		ne (First, Middle, Maiden Surna	
white and hard show the and hard hard hard hard hard hard hard har		ng Address (Straat and Number or Ru Native Dancer P		
Baltimore, Marylan permit. Pages 1 end 2 should be Department of Heelth and Mental Important: If Hern 27 is marked o any Injury or other traumatic ave page.	164 Burial 2   Cramation 3   Hamovel from State   _	matory or other place)		e, Pennsylvania
Balt permit. Departi Importi sny Inj pncs.	21. Signature of Futeral Service Courses  1. In the service Courses  22. Signature of Futeral Service Courses  1. In the service Course	g Memorial Cha ke, Rockville	pels, Inc. MD, 20878	
Box 68760, each certificate be executed attending physician and for use as the burial-transit clar/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)  Due to (or as a consequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence cause)  Due to (or as a consequence cause)  Due to (or es a consequence cause)	quence of):  so temy disecutive as the contraction of the contraction as the contraction as the contraction of the contraction	g arrest	
. 5 6 6	Pert II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23b. Did tobacco use o	contributa to the causa of death?
COrd require been si should	Chance Cerebral 15chemia	hyper tens 10	24a. Was an eutopsy performed?	24b. Were autopsy findings evailable prior to completion of cause of deeth?
0 6 20 1	Mysteyradism Spini Stem 25. Was case rategred to medical	25 Place of Dec	1 ☐ Yes 3 ☑ No	1 ☐ Yes 2 ☐ No
Division of Vital Re To the Hospital or Attending Physician: The Lawithin 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	examiner?    Yes   2   No	Other: Nursing H	lome 5 ☐ Residence 6 ☐ O 28d. Describe how injury occ	urred
Divi ous after ours after of filled in by	29a. Certifier  12 - Certifying Physician: To the best of my knowledge, death		281. Location (Street and Nun City or Town, Stata)	
To the Hospital Within 24 hours of To the Funeral I Completely filled Medical Ce	(Check only one)  2 Medical Examiner: On the basis of examination and/or invalid and manner stated.  29b. Signature and title of certifier		rred at the time, date and place	
5	30. Name and eddress of person who completed cause of death (Item 23a) (Type,	D:44907	Nov	3 ^M 2000
State Registrar	G[2] Montose Rod (1986)  31. Dete filed (Month, Day, Year)  NOV 0 6 2000	Sparks	30855	



State of Maryland / Department of Health and Mental Hygiene

				Certifica	ate of	Death	F	Reg. No.	0 3	7189	
Physician	Decedent's Name (First, Middle	, Last)					2. Data of Dea Month	ith Day	Yaar	3. Tima of Death	
/Medical	Desmond A. Stew						1	er 5, 2		6:30 pm	
Examiner	4a Facility Name (If not institution	and the second reserve	7)			4b. City, Town, or	Location of Death	4c. County	of Death		
	2725 Terrapin R					Wheaton		Montg			
Funeral Director	5. Social Security Number 455-07-7462	6. Sex 7. A 1 X M 2 □ F	ige (In yrs. las 85	Yrs. If Un Month	der 1 Year ns Days	Hours Min.	8. Date of Birth (Month, Day June I	6,1915	9. Birthple Countr Texas	nce (State or Foreign y)	
No.	Usuel Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Location					100	d. Inside City Limits	
23a or 28a-f show ust be notified at rai Director	Maryland Montgo	mery	Whea	ton						1 ☐ Yes 2 No	
be notified Directo	10e. Street and Number	*		101.	Zip Code			10g. Citizen of V	0g. Citizen of What Country?		
a di	2725 Terrapin F	load		2	0906			USA			
Examiner in by Fune	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceden	1941	1 Vas	cedent of I pecify Cub 2 No	Hispanic Origin? (Sean, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		4. Race - American Indian, Black, White, etc. Specify: White		
ted	15. Decedent (Specify only highes			16a. Decedent's U	sual Occup	petion	kina	16b. Kind of Bu	isiness/Indu	stry	
Completed	Elementary/Secondary (0-12)	College (1-4or		Mechanic		during most of world)	Aniy	Government			
	17. Falhar's Nama (First, Middla, I	Last)				18. Mother's Nar	ne (First, Middle,				
o Be	Alvin E. Stewar	t				Annie L	. Davis				
F	19e. Informeni's Name/Relationsh			19b. Mailing Addr	ess (Street	and Number or Ru	-	r, City or Town.	Stete, Zip (	Code)	
	Margaret W. Ste					n Road, W					
	20a. Method of Disposition		20b. Plac	ca of Disposition (interpretary)			1 Pa) 15	20c. Location -		m, State	
njury or	1  Burlal 2  Cremation 4  Donation 5  Other (Sc					al Cemete		Arlingt	on, V	A	
9000	21. Signalu on Funaral Service I	icensee		Franc	is J.	ess of Facility Collins				, MD 2090	
ian cal ner	23a. Pert T Enter the disease or shock, or heart failure. List of the control of	0	nogenic	Cancer		ng, such as cardiad	c or respiratory ar	rest,		Approximate Interval Between Onset and Death  months	
ē		Idion		s a consequence Pulmonary		rocie			2	years	
Examine		b				10515			- + -	years	
Exa	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury		Due to (or e	s e consequence	or):						
edical	that initiated events	c	Due to for ea	s a consequance of	of):						
Medi	resulting in death) Last	d	Out 10 (01 th	a consequence	,,,						
cian									1		
Physician/M	Part II. Other significant condition	ns contributing to death	but not resulti	ng in the underlyin	g cause gi	ven in Part I.	37			the cause of death?  ably 4   Unknown	
d by Physician/A											
Completed t			or and				24a. Was perfo	an autopsy rmed?	avai	ra autopsy findings ilable prior to appletion of cause	
Completed								X	3,710.5	eath?	
		.,					101		10	Yes 2 No	
Be	25. Was case referred to medical examiner?	Hospital:			100	h	ath (Check only o				
. To	1 Yes 2 No	1 Linpai			DUA	4 Li Nursing F	tome 5 Resid	lenca 6 Oth		)	
Medical Certification:	1 ØNatural 5 ☐ Pending 2 ☐ Accident Invastig	ation	ey Year)	8b. Time of Injury M	28c. Inju Wo	rk? ]Yes 2□No	280. Describe r	low injury occur	red		
entific	3 Suicide 6 Could r 4 Homicide determine	ned 286. Placa of I	njury - At home etc. (Specify)	e, farm, street, fac	tory, office		28f. Location (5 City or Tox		er or Rurei	Routa Number,	
edical C		Physician: To the best examiner: On the basis and manner:	of examination								
Me	29b. Signature and title of certifier				29c. Lican	sa number		29d. Data signe	d (Month, D	lay, Year)	
JA	10 1			27	D 54	6486		Novembe	r 6	2000	
	30. Name and address of person v	who completed server of	death (Itam 0	20) (Type Brins)	ול ע	J-700		MOVEINDE		2000	
4 11					West	inctor D	0 20207	d ²			
State	Andrew Shorr, 31. Date filed (Month, Dey, Year)		eorgia trar's Signatur	The I	wasn:	ington, D	20307				
State				la la	- 10 1						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year **Physician** Strand 1:35 pm Kai 10 31 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Manor Care Bethesda Bethesda Mortgonery If Under 1 Year Months Days 6. Sax 1 2 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Hours 93 Yrs. 325-28-9597 Director Feb. 27, 1907 Denmark Usuel Residance of Deceden 10c. City. Town or Location 10a. Stete 10b. County 10d. Inside City Limits 28a-f show the Maryla 1 X Yes 2 No Director DC Washington, DC N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? b U.S.A. flarns 23a 3200 Rowland Place, NW 20008 Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 XI Yes 2 □ No If Yas, Give Yaar or Datas: 1942-45 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 Never Merried 2 Married *natural", or the Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White permit. Pages 1 and 2 should be filled within 72 h. Department of Health and Merkal Hygiene. Important: If then 27 is marked other than "nature any Injury or other traumatic event, the Medical other. Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondary (0-12) Astronomer US Naval Observatory 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Peter Strand Constance (Unknown) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emilie R. Strand (Wife) 3200 Rowland St., NW Washington, DC 20008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 X Cramation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) National Crematory 11/4 Falls Church, Virginia 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility JOSEPH GAWLER'S SONS, INC. 8 23a. Part1. Enter the diseesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Washington, DC 20016 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Causa (Finel disease or condition resulting in death) 6 days Examiner Physician/Medical Examiner Cerebro Vascular sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) physician the burial P.O. Box 68760. Dua to (or as a consequence of): signed by the at 1 be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Denentia Division of Vital Records. Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4K Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No this funeral 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Aftert 1 Neturei 5 Pending investigation ne Hospital or Attending n 24 hours after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 198 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier completely (Check only one) within 2 To the 100 29c. License number 29d. Dete signed (Month, Day, Year) alch Mathen

State Registrar

31. Dete filed (Month, Day, Year) NOV 0 7 2000

ALOK MATHUR, M.D.

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

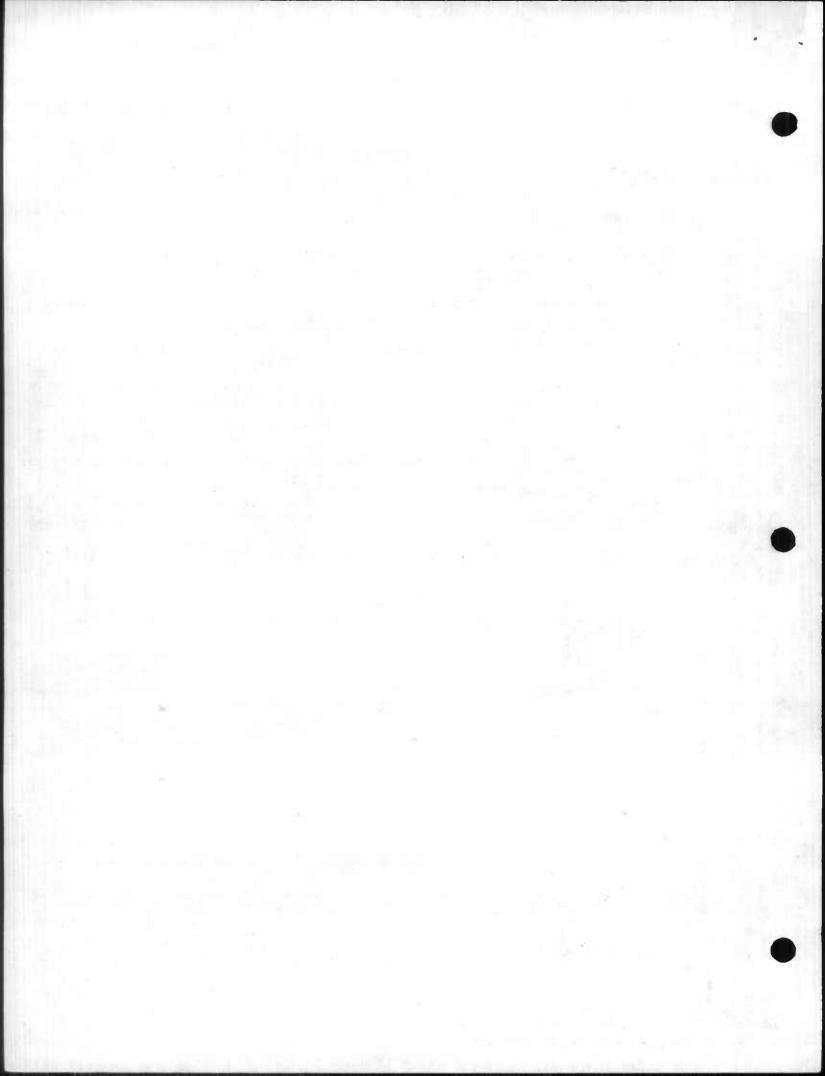
32. Rehistrer's Signeture

- Physicisn

4000 Olney-Layforsville Rd Olney, MD

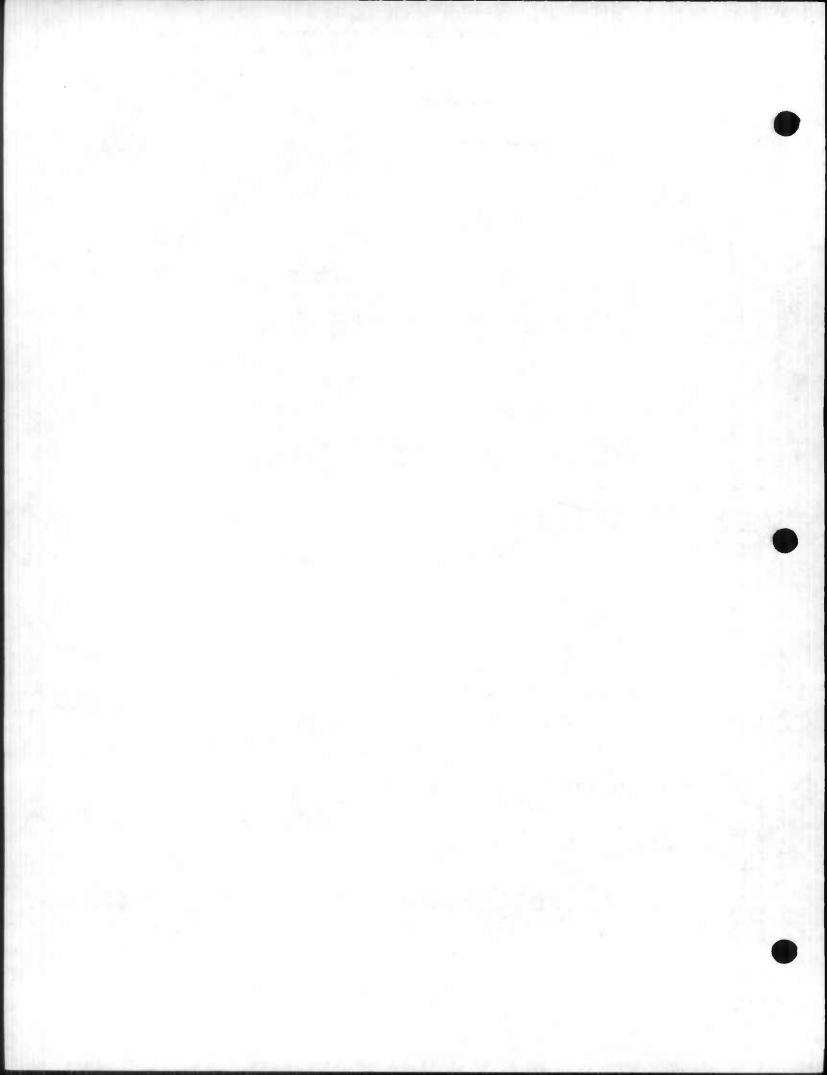
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October 31, 2000



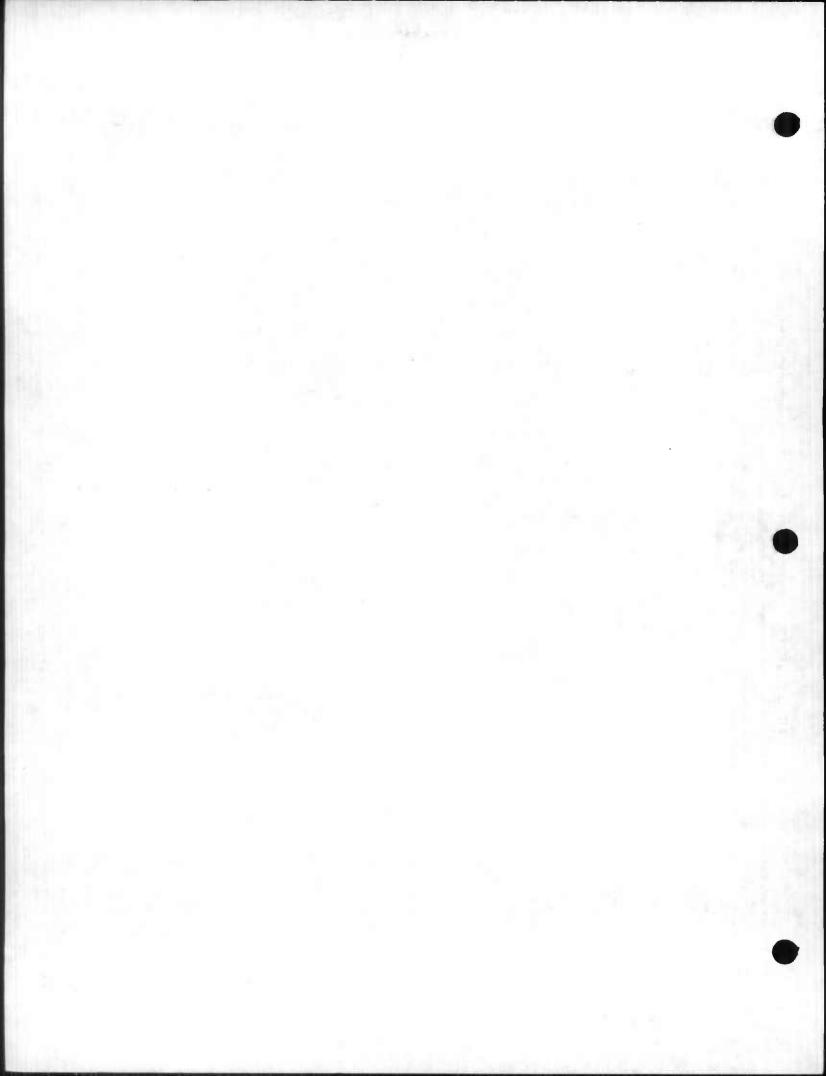
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Ce	ertificate o	f Death	F	Reg. No.	01121			
hysician	Decedent's Neme (First, Middle, Las Robert	Scheck	nter		4.0	2. Dete of Dea Month		3. Time of Deeth  11:05 AM			
/Medical xaminer	4e Facility Neme (If not institution, give	e street end number)			4b. City, Town,	or Location of Death					
Administ	Hebrew Home of G	reater Washir	aton		Rock	ville	Montgome	rv			
neral	5. Social Security Number 6. S		s. lest birthde		ar If Under 24 H	rs. 8. Dete of Birtl	h 0.0%	thalass /Ctata or Fornier			
ector	The state of the s	M 2□F 57	Yrs.	Months Dey	Hours M	oct. 17	, 1943 C	Romania			
44	10a. Stete 10b. County	10c. (	City, Town or I	Location				10d. Inside City Limits			
r mant be notified at neral Director	Md. Montgom	ery	Rockvi					1 ☐ Yes 2½ No			
al Dire	10e. Street and Number 5826 Tudor Lane			10f. Zip Code 20	852		10g. Citizen of What Country?				
by Funeral	11. Merital Status  1 □ Never Merried 2 ☑ Merried  3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1  Yes 2 No If Yes, Give Yeer or Detes:	U,S. 13	Was Decedent of If Yes, specify C	uban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	o- 14. Rece - American Indien, Bleck, White, etc.  Specify: White				
pet	15. Decedent's Ed	lucation	16a. Dec	edent's Usuel Occ	cupetion		16b. Kind of Business	/Industry			
Completed	(Specify only highest gra	College (1-4or 5+)		ngineer	ne during most of v ired)	vorking	Electric	al			
	17. Fether's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Sumeme)				
Be	Leon Schech				Anna						
10			100 11	91 - A -1				Zin Codo'			
	19e. Informant's Name/Reletionship (	ype, Print)			ress (Street end Number or Rurel Route Number, City or Town, State, Zip Code) angley Ct. #F636 NW Washington, DC 20016						
	Galia Schechter/	Daughter	394	40 Langle	ey Ct. #F						
and on	20a. Method of Disposition  1 Disposition  2 Cremetion 3 Disposition	D	cemetery, cr	position (Neme of emetory or other p	olece)	Dete	20c. Location - City or				
	4 Donetion 5 Other (Specify		Judean	Memoria:	l Gardens	11/06/00	Olney, M	ld.			
	21. Signeture of Fundual Service Licen										
	Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, Md. 20										
	23a. Part1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart future. List only one cause on each line.										
	shock, or heart trillure. List only	one cause on each line.			,,,,,,,	and or rouph droit, or		Approximate Interval Between Onset and Death			
	Immediate Cause (Fine)		•								
	disease or condition resulting in deeth)	CINOMA	2 Years								
2											
lne		b									
Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or es e cons	equence of):							
edical	thet initieted events	C. Due to	(or es a conse	equence of):							
Med	resulting in death) Last										
		d									
Physician/	Pert II. Other significant conditions of	potributing to death but not s	neulting in the	undarlying called	given in Part I	23h Did i	obaccouse contribut	e to the cause of deeth			
hys	reitii. Other significant conditions of	A minuting to death out not in	esuiting in the	underlying cause	given in Petti.			Probably 4 Unknow			
2	MALIGNAN. MY	reatensien.	Nore	0101610	21715	_	168 2L NO 3L	TODEDTY 4 DOTATION			
Completed by	Henn disense	· (0N/02710		at Fri	•		an eutopsy 24b.	Were eutopsy findings evailable prior to completion of cause			
ldu								of death?			
S	DIBBETOS MELL.	TUS. CHRONCE	08170	verious	ULMOKA	0/ 0/200	res 2 No	1 Yes 2 No			
	25. Wes case reterred to medical					Death (Check only o					
0	examiner?	Hospitel: 1 ☐ Inpatient 2	☐ ER/Outpeti	ent 3 DOA	Other: 4 Nursin	g Home 5 Resid	dence 6 Other (Sp.	ecify)			
-	27. Menner of Death	28a. Dete of Injury	28b. Time		jury et	28d. Describe i	how injury occurred				
100	1 ☑ Neturat 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey Year)	Injury		Vork? ☐ Yes 2 ☐ No						
Certification:	3 Suicide 6 Could not be determined		home, farm, s	street, fectory, office	се	281. Location (S City or Tox	Street end Number or F vn, Stete)	Rurel Route Number,			
edical C		yelclan: To the best of my k liner: On the basis of exami end manner steted.									
M	29b. Signeture and title of certifier	one manner states.		29c 1 ice	ense number		29d. Date signed (Mon	oth Day Year)			
_	200. Orginolog and this distantial	01									
	( ) au )	Sur hal	CON	12	2131		11/6/00				
	30. Name and address of person who	completed cause of deeth (it	em 23a) (Type	e, Print)							
	Buzzeri L. R.	into, MO 4		. 2/4/0 . 200	- 411-	17.14 1.19	A Alexan Sant	D.C. Anna			
ite	31. Dete filed (Month, Day, Year)	32. Régistrer's Sig		N. K. C. C.	U. DUR.	PATOL WIT	AND LOW	D.C. GOOG			
-	MO1/ 0 9 2	000	, 4	100	1.						



			1100001	State of Mai		Department of Certificate o	Health and M	lental Hy	giene 🕝 (	37192
			. Decedent'a Nama (First, Middla, Last)					2. Data of De		3. Tima of Death
	Physiciar /Medica Examine	1	Gladys M. Thomas a Facility Nama (If not institution, give s	street and number)			4b. City, Town, or Lo	Month Novembe	r 13, 20	000 00:45
	Funeral Director	5	Sunbridge Care Ce: Social Security Number 6. Sex 218-18-5330	7. Aga	(In yrs. last bi	rthday) If Undar 1 Ya Yrs. Months Day	s Hours Min.	8. Data of Bird (Month, Da eptembe	Cecil ty, Year) er 19,191	9. Birthplaca (State or Foreign Country) 5 Maryland
	Manyland f show	1	Oa. Stata 10b. County Maryland Cecil		10c. City, Tow North	n or Location				10d. Inside City Limits 1 X Yas 2 No
	or 28a-f	1	Oe. Street and Number		NOLLII	10f. Zip Code	a .		10g. Citizan of W	hat Country?
	3a o		104 River Manor Ap	artments		21901			United S	tates
020	72 hours after death with the Maryland natural, or Nerra 23a or 28a-f show dical Evandor must be notified at	1 1		12. Was Decedent Ev Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas:		13. Was Decedent of	of Hispanic Origin? (Spuban, Mexican, Puarto No Specify:	ecify Yas or No	14. Raca	- American Indian, c, Whita, atc.
Maryland 21215-0020	c 1 6 4	Completed	15. Decedent's Educ (Specify only highast grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)			na during most of work ired)	ing		siness/Industry change at
and 2	正工をを 。	0 1	7. Father's Name (First, Middle, Last)		AS	sistant Mar	18. Mothar's Nam			n Proving Ground
17	should be and Mental or marked or marked or To Do		Harry E. Moore	ne. Print)	191	o. Maiting Addrass (Stre	Ada E. G		er. City or Town. S	Stata, Zip Code)
Baitimore, Ma	of Health of Health f Rem 27 I	Ţ		Brother amoval from State	90 20b. Place of cemate		nor Apartm Placa) Nove	ents, N Data mber 16,	orth Eas	t, Maryland 2190 City or Town, State ast, Maryland
Bail	permit. Pag Department Important: It any Injury o	- 10	21. Signature of Funeral Service License				drass of Facility neral Home t, Marylan		outh Mai	n Street,
	Physician /Medical Examiner	li d	23a. Part1. Entar tha disaase, or complishock, or heart failura. List only or mmediata Causa (Final disaasa or condition esulting In death)			not antar tha mode of of the consequence of):	dying, such as cardiac		/	Approximate Interval Batween Onsat and Death
,092	be executed ician and burial-transit		Sequentially list conditions, tany, leading to immediate access. Enter Underlying Cause (Disease or injury	D	ua to (or as a	consequance of):				
Box 6876	at the death certificate by the attending physic etached for use as the both the color of the co	3 t	hat initiated evants asulting in death) Last	Di	ua to (or as a	consequanca of):				
	death e atte ed for	P	art II. Other significant conditions con	tributing to death but	not rasulting	n tha undariving causa	givan in Part I.	23b. Dld	lobacco uss con	tributs to the causs of death?
s, P.O	that the		- ASOVD			- CHF	re e	10	Yss 2□ No	3□ Probably 4 Unknown
Vitai Records,	been shoul	Dieter 1	- MILL WALK	/					an autopsy imed?	24b. Were eutopsy findings available prior to completion of cause of death?
R	The law	5	-HYPO THYKOH					10	Yas No	1 Yas 2 No
ita	certificate rector, pag		5. Was case referred to medical examiner?				26. Place of Deet	th (Check only	ona)	
of V	this phi	2	1□Yes 2□No	ospital: 1   Inpatient		utpatient 3L DOA			dence 6 □Othe	
no	tending P Seath. tor: After t the funer	2	7. Menner of Death  Natural 5 ☐ Pending	28a. Data of Injury (Month, Day		Tima of 28c. In V	Nork?	28d. Dascribe	how injury occurre	ed .
Division	C 8		Accident  3 Suicide 4 Homicida  invastigation 6 Could not be datarmined	28a. Place of Injury building, atc.	y - At homa, f (Specify)	arm, straat, factory, offi		28f. Location ( City or To		er or Rural Routa Number,
	Hospi 4 hou Funer lely fill	2000			xamination ar	a, daath occurred et the nd/or invastigation, in m				
	To the within 2 To the complete		9b. Signature and title of ceptifier	1 10	0	29c. Lic	ense, number		29d. Date signed	(Monthy Day, Year)
	8	3	0. Nama and addrass of person who go	mpleted causa of das	ith (Itam 23a)	(Type, Print) 5	UNION	gre.	Ad 6, 1	11 21098
	State Registrar		1. Data filed (Month, Day, Year) NOV 13 2000	32. Registrar	's Signature	Sports	/	11	1	/

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month 09 **Physician** 5:00th 20 /Medical Neme (If not institution, give street and number, 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner radow Kent Lar E If Under 1 Year If Under Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Dete of Birth (Month, Dey, Funeral Months Days Hours 1□M 25F 74 Director 57-40-0753 10-27-25 Maryland Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Kent Worton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 items 23a 24931 Lambs Meadow Road 21678 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Bleck, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: Black by ⊋□ Widowed 4□ Divorced Completed 16e. Decadent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grede completed) ls marked other than Elementery/Secondary (0-12) College (1-4or 5+) someone elses 10th Homemaker home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Howard Jones Hallie Derry (Jones) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it if item 27 is Thomas Jones-Nephew 25501 Stillpond Neck Rd. Worton, MD 21678 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ *Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Capitol Crematory 9/27/00 Dover, DE Merei Service License 22. Name end Address ot Facility Bennie Smith Funeral Home Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart tellure. List only one ceuse on each line. 21601 Approximate Intervei Between Onset end Death **Physician** /Medical Immediete Ceuse (Final immedi of disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760, Physician/Medicai the Due to (or es a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were eutopsy findings evailable prior to Completed 24a. Wes en eutopsy anneroma, left spheroid wrig, completion of cause has excessed 1990 1□ Yes 2No 916 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attanding Physician: 24 hours efter death. Funeral Director; After this certifica tely filled in by the funeral director, p Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 25 No Certification: To 27. Manner of Death 28e. Dete of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending Investigation 1 ☐ Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 I Homicide within 24 hours e To the Funeral D completely filled edicai Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

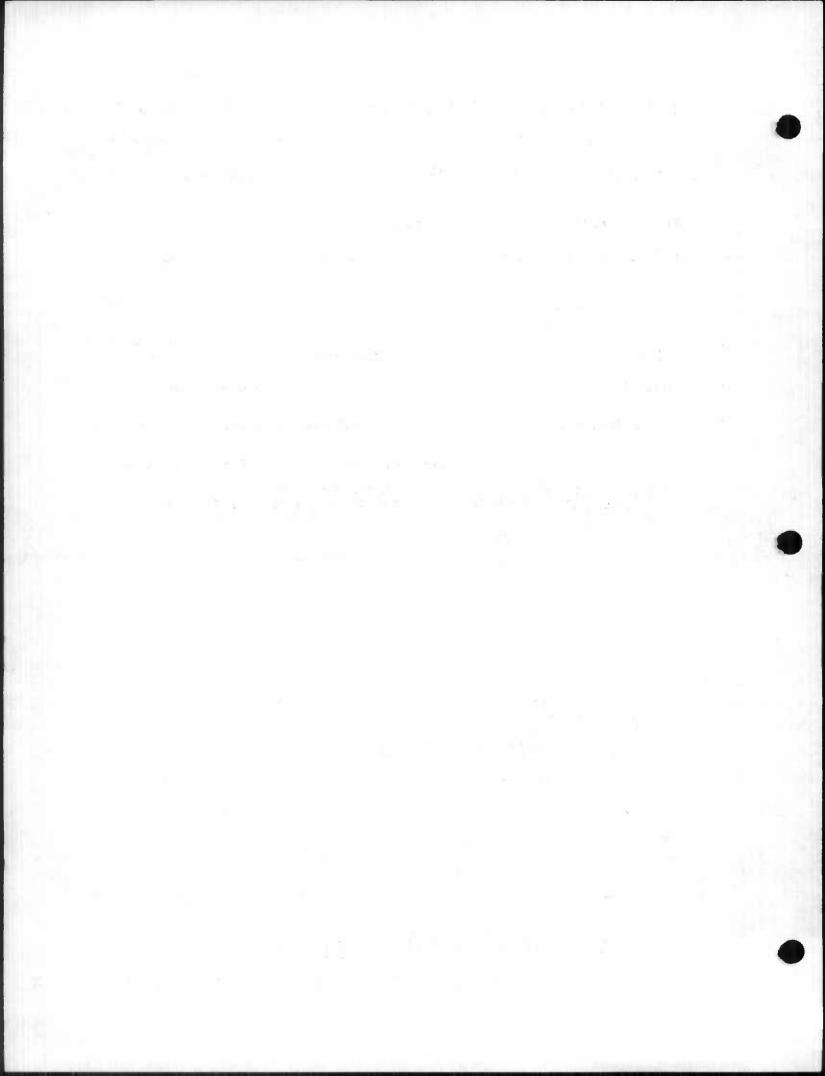
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 94 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ousan K. Ross, M.D Washington Ave. Chestertown, Md. 21620

32. Registrer's Signeture

State Registrar . Dete filed (Month, Day, Year)

2 7 2000

SEP



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dey Month Year **Physician** MAGGIE 11:38P TILGHMAN 01 00 /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HILLS NURSING CENTER 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) QUEEN ANNES JOBSICA 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director -14-30-7815 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 □ Yes 2 □ No Director QUEEN ANNE'S o m QUEENS TOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21658 605 CARMICHAEL KOAd Funeral S /A 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 HO Specify: þ 3 ₩idowed 4 Divorced BIACK Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 7 in 2001 PRIVATE FAMILY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANDREW JOHN GIBPS DEBIAR (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 at Department of Health and Important. If them 27 is n any injury or other traus once. 8782 GEORGE TOWN RD. Chestertown, and 21620 AND MAEHENLY. DAUGHTER 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) males FEMALE BENEFICAL 11.04.00 RFD CENTREVILLE, TOD 21. Secultura of Funeral Service Licensee 22. Name and Address of Facility Effort the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Physician /Medical immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. IAMS 1 Yes 2 No 3 Probably 4 Unknown INSUFFICIENCY by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 10 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

physician and the buriel-trans Box 68760. 88 esn ed by the a Records, P.O. signed by the peen page 2 has certificata Division of Vital Attanding Physician: director this funeral Aftar i or Attanding after death. Director: Aft

the Marylend

deeth

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at

a filed within 72 hours after call Hygiena.

should be h and Mental 7 is marked or

Maryland 21215-0020

Baltimore,

Certification: edical

29a. Certifier (Check only one)

29b. Signature and title of certifier

24 hours a Hospital Within 2

> State Registrar

se of death (Item 23e) (Type, Print) 30. Name and address of person who 7. Cigene Cric

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinering end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

Centreville, und 214,77 2540

31. Dete filed (Month, Day, Year) 32. Registrer's Signature NOV - 6 2000

Type of Fillt ill black indenbie lik. Assure All Cop	les Ale Legibi	C.
State of Maryland / Department of Health and Mental	Hygiene [	37195
Certificate of Death	Reg. No.	01100

1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death NOVEMBER 12, 2000 **Physician** MARY SUE TWINE 12:30 AM /Medical 4a Fecility Name (II not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CHARLES LA PLATA CIVISTA MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Min. | MARCH 6, 1928 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10M 20F TENNESSEE 226-26-2475 72 Director Usuel Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show must be notified at 1 Yes 2 No Director MARYLAND WALDORF CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Nerna 23a or U.S.A. 20602 3412 VELVET ASH COURT 12. Wes Decedent Evar in U.S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indien, Biack, Whita, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: Specify: WHITE natural, or Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) filed within 7 Hygiene. Elementary/Secondery (0-12) U.S. FEDERAL College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Importants if tem 27 Is marked other that any Injury or other traumatic avent, that page. COMPUTER OPERATOR GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be BETHANY MAE CROWDER HICKS ALFRED ALEXANDER FERGUSON 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3412 VELVET ASH COURT, WALDORF, MARYLAND 20602 LEWIS E. TWINE, SR./HUSBAND 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removel from Stete TRINITY MEMORIAL GARDENS 11/16/2000 WALDORF, MARYLAND 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility THE HUNTT FUNERAL HOME, INC. JOHN P. KNISLEY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart feilure. List only one cause on each line. M01164 20604-0156 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Final diseese or condition resulting in deeth) 12 HOURS CONGESTIVE HEART FAILURE Examiner Due to (or as e consequence of): Examiner 6 WEEKS METASTATIC LIVER CANCER that the death certificate be executed physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical the Due to (or es a consequence of). P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yee 2 No 3 Probably 4 Unknown be det Division of Vitai Records. þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? Completed page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 💆 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 1 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Neturel To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homleide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end mennar steted.

State Registrar

31. Dete filed (Month, Day, Year) NOV 1 4 2000

30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print)

29b. Signetura and title of certifies

THOMAS GAGE, MD, 1207 OLD LINE CENTER, SUITE 200, WALDORF, MARYLAND 32. Registrar's Signature

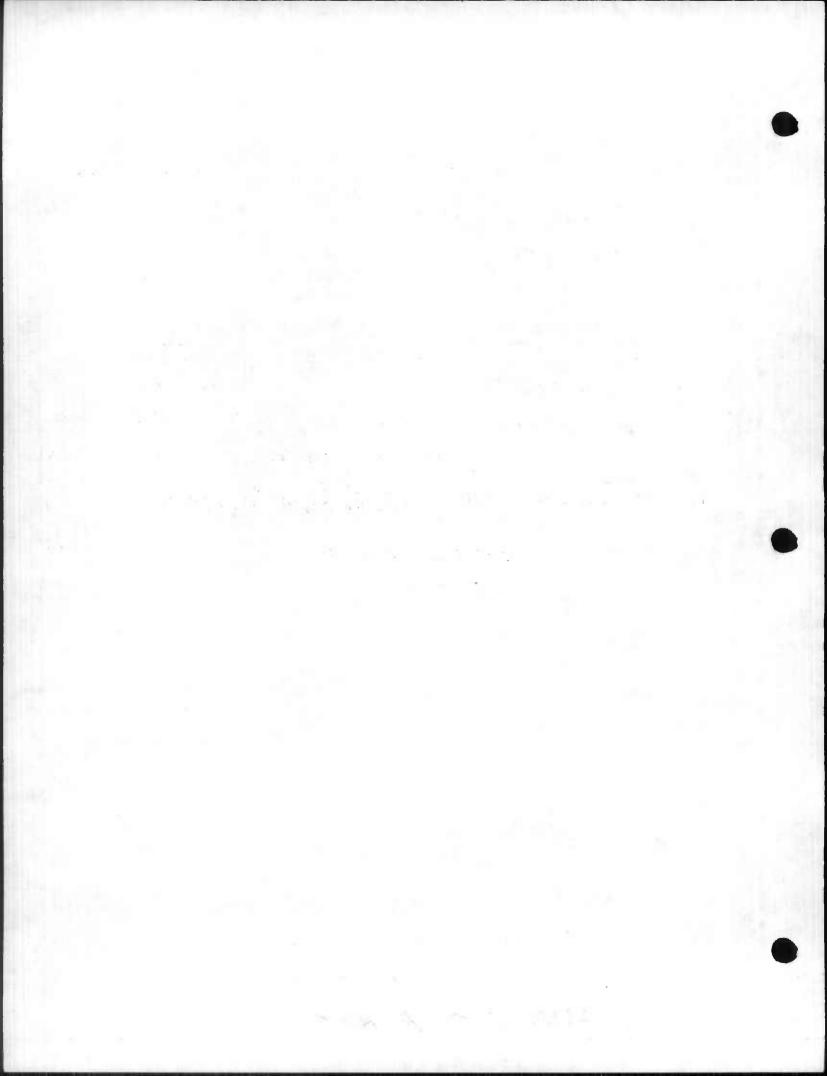
29c. License number

D0021607

29d. Date signed (Month, Dey, Year)

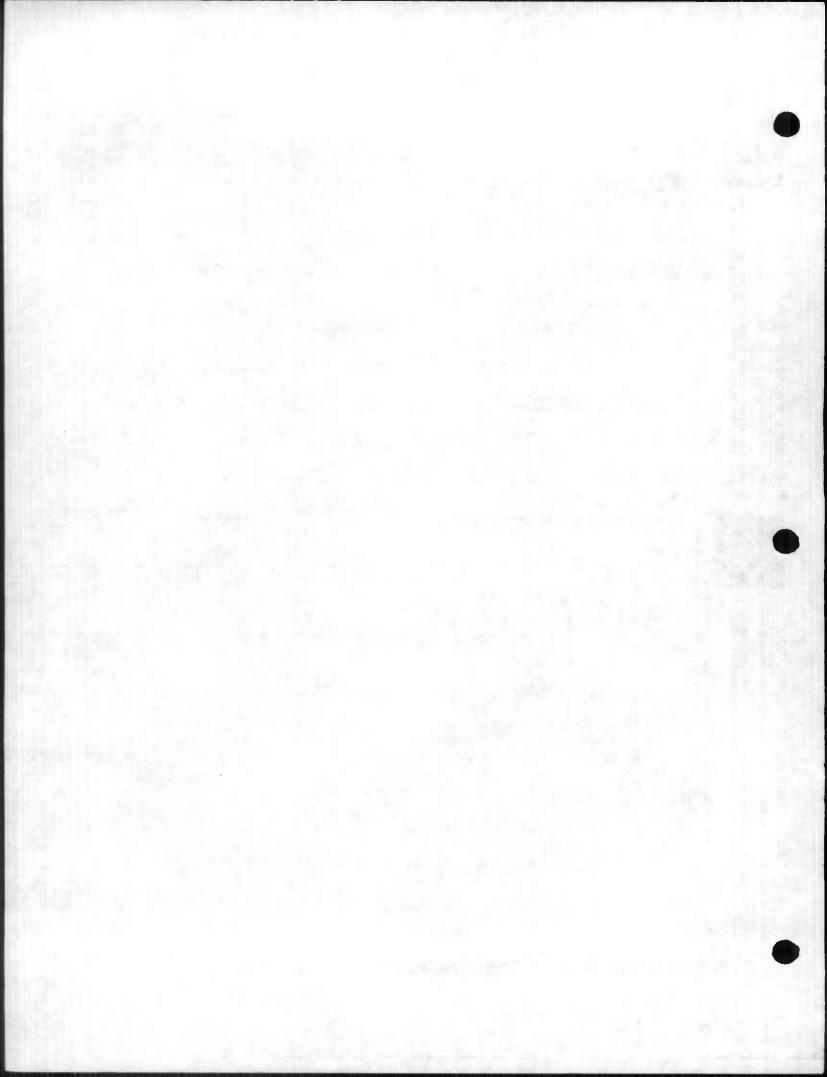
NOVEMBER 14, 2000

20602



State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 1 9 6

				Cer	tificate	of	Death			Reg. No.		
	1. Decedent's Name (First, Middle,	Last)							2. Dete of D	eath		3. Time of Death
Physician	U Dendan To	C							Month	Dey 2	Year	11./.EDM
/Medical	W. Davidson Te:  4a Facility Name (# not institution,		her)			-	4b. City. To		Novemb ecation of Dea		000 y of Death	11:45PM
Examiner			567							70. 00011	,	
	Holy Cross Hos			Etak da di	If Under 1		Silve	r Sp			tgome	
Funeral	5. Social Security Number	5. Sex 7 1 ☑ M 2 ☐ F	'. Age (fn yrs. last i	Yrs.		Deys	Hours	Min.	(Month, D	ey, Year)	9. Birth	place (State or Foreign intry)
Director	577-60-7021		92	113.					Oct. 2	1,1908	Wash	ington, D.C
2 .	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation							10d. inside City Limits
n 72 hours after death with the Manyland "natural", or leans 25a or 28a-f show edical Examiner must be notified at leted by Funeral Director	Tou. Other		100. 0%, 10	>WII 07 E.O.	Odirori							1 Yes 2 No
No age of	Maryland Montgo	nery	Si	ilver	Sprin	ng						2.
or 28efs to 28efs be notified Director	10e. Street and Number				10f. Zip C	ode				10g. Citizen of	What Cou	intry?
at 123 a	103 Southwood A	venue				209	01			USA		
r Hams 23a sinar must Funeral	11. Maritel Status	12. Was Deced	dent Ever in U,S.	13. V	Was Deceder f Yes, specify	nt of H	lispanic Or	ngin? (Spo	ecify Yes or N		ca - Ameri	ican Indian,
netural, or ly dical Examina ated by Fu	1 Never Married 2 Marrie	d 1 Yes 2	2 ☑ No		1 ☐ Yes 25							, 010.
D En	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or De	tes:		1 105 Z	Š MO	Зреспу.			Speci		ite
A the Medical	15. Decedent's		16	Sa. Deced	lent's Usual (	Occup	ation	at at another	tu a	16b. Kind of E	Jusiness/Ir	ndustry
ple ple	(Specify only highest Elementary/Secondary (0-12)	College (1-	400 5 1)	life. L	kind of work DO NOT use	retired	<i>du</i> nn <i>g m</i> os d)	St of Work	ing			
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	17. Father's Neme (First, Middle, L		110	JICIE	II DCI	VIC				e, Meiden Sume		Crimono
92 B III	17-1 7 - 1						n 1	1. D	4 -1			
To	Walter Lambert					0			ickson		- C+++ 7	in Ondal
2 2	19a. informant's Name/Relationsh	p (Type, Print)	1	9b. Mailin	ng Address (3	Street	and Numb	er or Hur	ei Houte Num	ber, City or Town	i, Stere, Zi	ip Code)
ilem 27 other tr	S. Dickson Tenn	ey (son			Queens		od Dr	ive		e, Virg	inia	22015
8	20e. Method of Disposition		como	of Dispos tery, crem	sition (Neme	of er plea	ce)	į	Date	20c. Location	- City or T	Town, State
2 E	1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.			iloge	tan C	rom	ators	, 11	/5/00	Alexano	iria	Virginia
Injury 8	21. Signature of Funeral Service L	censee	THEET	22	. Name and	Addre	ss of Facili	ity				
1	NO V. 51.0			Fr	cancis	J.	Coll	ins	Funera	1 Home,	Inc.	
	1. New Spile	b.		50	00 Univ	ver	sity	B ₁ vd	W.,S	ilver Sp	oring	MD 20901
	23a. Part. Enter the disease, or c shock, or heart feilure. List o	omplications that ca nly one cause on ee	used the death. Di ch line.	o not ente	er the mode (	ot dylin	ng, such as	cardiac (	or respiratory	errest,	1	Approximate Interval Between
ician											1	Onset and Death
dical niner	Immediate Cause (Finel disease or condition	Conge	stive Hea	art F	Failure	9						weeks
	resulting in death)	6. 001180	Due to (or as									
ē -		Coron	ary Arten	rv Di	sease							vears
nal-transit Examiner	Sequentially list conditions	b. <u>001011</u>	Due to (or as							19.35		70020
mart Ex	if any, leading to immediate cause. Enter Underlying											
edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	С.	Due to (or as	a consequ	neuca ot).							
ed is	resulting In death) Last		Due to (or as	a consequ	derica orj.							
clan/Medical Examir		d										
d be detached for use									1			
ysi ysi	Part il. Other significant condition	s contributing to dea	th but not resulting	g in the ur	nderlying cau	ise giv	en in Part	I.	23b. Die	d tobacco use c	ontribute	to the cause of death?
Ph Ph	Hypothyroidism								10	Yes 20 No	3 Pro	obably 4 Unknown
2 2												
should									24a. Wa per	s an autopsy formed?	8	Vere autopsy findings veilable prior to
page 2 should be detached for use											0	completion of cause of death?
director, page 2									15	Yes 2⊠No	1	Yes 2 No
g 0	25. Was case referred to medical	1					00 01	101				
Be	examiner?	Hospital: 30.				Oth	or.		h (Check only			
al director, pag To Be Co	1 Yes 2 No	1 45J in		•	t 3 DOA		4 LI N			sidenca 6 🗆 O		cify)
uner CO	27. Manner of Death  1 ANatural 5 Pending	28a. Date of (Month)	Dey Year)	b. Time of Injury		c. Injur Wor			28d. Describe	now injury occu	ILLEG	
in by the fune	2 Accident Investige				М	10	Yes 2	No				
4 4	3 Suicide 6 Could no determine	ed 200. Place	of Injury - At home, g, etc. (Specify)	, farm, stri	eet, factory, o	office				(Street and Nun own, State)	nber or Ru	rel Route Number,
ed in by the funera Certification:												
in in		Physician: To the b										
pletely fill	(Check only 2 Medical E	caminer: On the bas and mann		and/or inv	vestigation, ir	n my o	pinion, de	ath occur	red at the time	a, date and place	, and due	to the cause(s)
To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	29b. Signature and title of certifier	01			29c. l	Licens	e number			29d. Dale sign	ed (Month	n, Dey, Year)
0	b V. N	///	44.0			0 = 0					0	2000
10.50	no way	100pe	( ) ( )	a) /*		379	2			Novembe:	c 3,	2000
	30. Neme and eddress of person w											
	Irnst Oser, M.D		Georgia		nue S	ilv	er Sp	oring	,Maryl	and 20	902	
State	31. Date filed (Month, Dey, Year)		gistrer's Signeture	4	Span	1						
Registrar	NOV 06 2	000	was /	U.	popor	121						



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Dey Yeer NOVEMBER 14, 2000 GAYLE THEPAUT 6:24 PM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE CITT. DALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Deys Hours Min. | 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 25 F 231-72-6089 48 Yrs. Virginia Oct.3,1952 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Maryland Howard 1 ☐ Yes 2 No Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3637 MacAlpine Road 21042 United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merifal Stetus 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Nuclear Medicine Technologist General Electric 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Bernard Petroff Jackie Berz 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Robert Thepaut (Husband) same as #10 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removal from Stete Columbia Memorial Gardens 11/17/00 Columbia, Maryland 4 Donetion 5 Other (Specify) 22. Name and Address of Fecility Donald V. Borgwardt Funeral Home, P.A. 21. Signeture of Funeral Service Licensee Matthew Brown 4400 Powder Mill Rd. Beltsville, Maryland 20705 23e. Penf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finel · INTRACRANIAL HEMORRHAGE diseese or condition resulting in death) Due to (or es e consequenca of): MYELOGENOUS LEUKEMIA. Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Niknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed?

**Physician** /Medical Examiner

death certificate be exec

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Directo

Funeral

þ

Examiner

**Funeral** 

Director

then "netural", or items 23s or the Medical Examiner must be a

altimore, Maryland 21215-0036

nit. Pages 1 and 2 should be tiled within 2 antment of Health and Mental Hygiene. cortant: if item 27 is marked other than 71

physician and s the burial-trans 60 USB bengis page 2 should b Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifies

Examiner Physician/Medicai by Completed Be 0 Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events thet initieted events resulting in deeth) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 1 Yes 20 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29c. License number

1296

st. Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

NOVEMBER 14, 7000

State Registrar

illed in by

edical

To the Hospital within 24 hours a To the Funeral Completely filled

Fernando Lo NOV 2 2 2000

29b. Signatura, and title of certifier

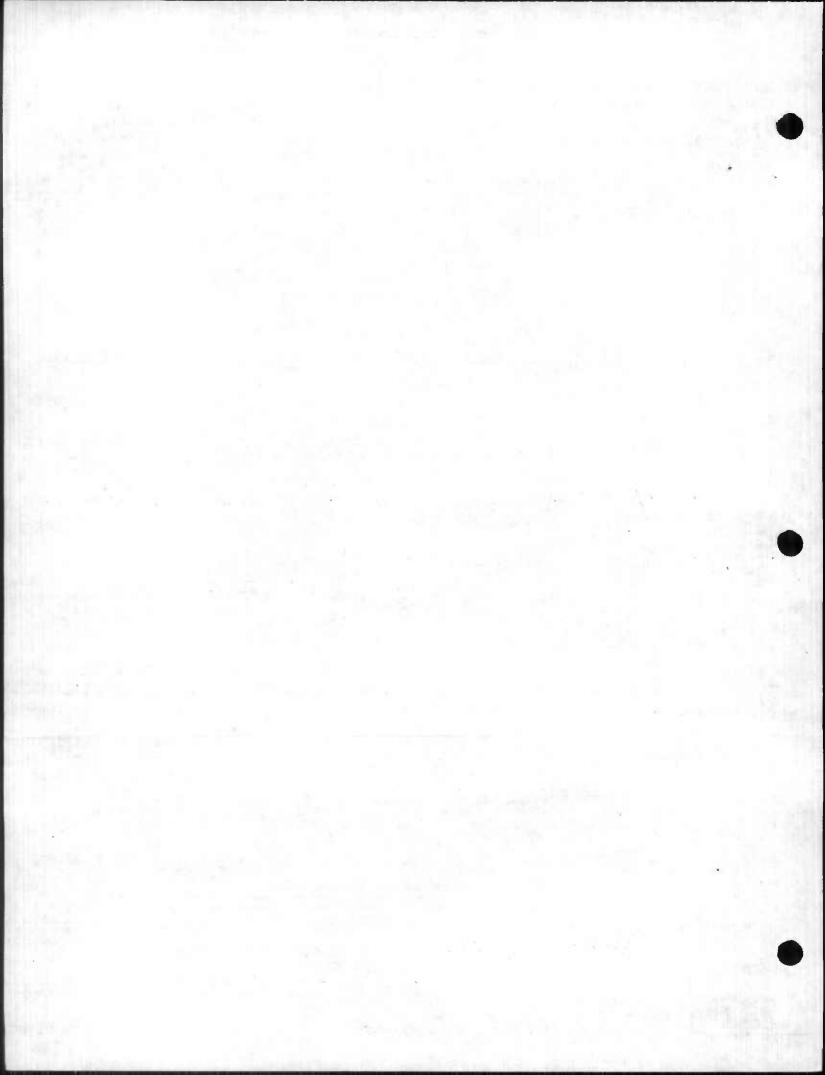
29a. Certifier

mi), 22 South Greene 32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PLE

BOCK ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 8,2000 10:30pm **Physician** Carl A. Talbert Sr. /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner | Silver | Sp. | Silver | Sp. Holy Cross Hospital 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 10XM 20 F Yrs Director 72 579-30-9176 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylar r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Prince Georges Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6326 Martin Luther King Hwy 20743 U.S.A. Funeral 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 187 Yes 2 No 1951 If Yes, Give Year or Detes: 1953 hours after 1 Never Merried X Merried 8 Specify: Black Maryland 21215-0036 1 Yes 2 No Specify: å 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 20 then. Elementery/Secondery (0-12) College (1-4or 5+) Federal Government permit. Pages 1 and 2 should be flied. Department of Health and Merital Hyg Important: If Item 27 is marked other any Injury or other traumatic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Talbert Hilda Pinkney Archibald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20743 19a, informent's Neme/Reletionship (Type, Print) 6326 Martin Luther King Hwy Capital Heights MD R. Talbert Wife Anne Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, State 1 Quriel 2 Cremetion 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Maryland VeteransCem.Nov.16,00 Cheltenham MD 22. Neme end Address of Fecility 21. Signature of Funerel Service Licentee Adams Funeral Home P.A. Aquasco MD M191 20608 23a. Pert1. Entering disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Metastatic Colon Carcinoma Examiner Due to (or es e consequenca of) Examine burial-transit death certificate be executed Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last and Due to (or as a consequence of): physician sthe burial Physician/Medical Due to (or as a consequence of): attending USB | 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 3 Unknown that Pancytopinia P requires 24b. Were sutopsy findings available prior to 24a. Was an autopsy performed? page 2 should Completed peed Myelodysplastic Syndrome completion of cause of death? WE certificate has The 1 Tes 2 No 1 ☐ Yes 2 ☐ No Gout, Hypertension of Vital Physician; 25. Was case referred to medical examiner? funeral director, Be 28. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2X No this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? Certification: After Division Attending val or Ah.

value after deah.

v Director: Ah.

to by the fire 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide e Hospital or A 24 hours after a Funeral Dire-detely lilled In b Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only within 2 To the 29b/Signati 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number D34472 November 10,2000 30. Name and address of person who completed cause of seath (figm 23a) (Tipe, Print) Lynne Diggs MD 1500
31. Date filed (Month, Day, Year)
NOV 1 4 2000 Glen Rd., Silver Spring MD 20910 Locust

State Registrar

**DHMH 16 Rev 6/95** 

ORIGINAL

32. Pegistrer's Signeture

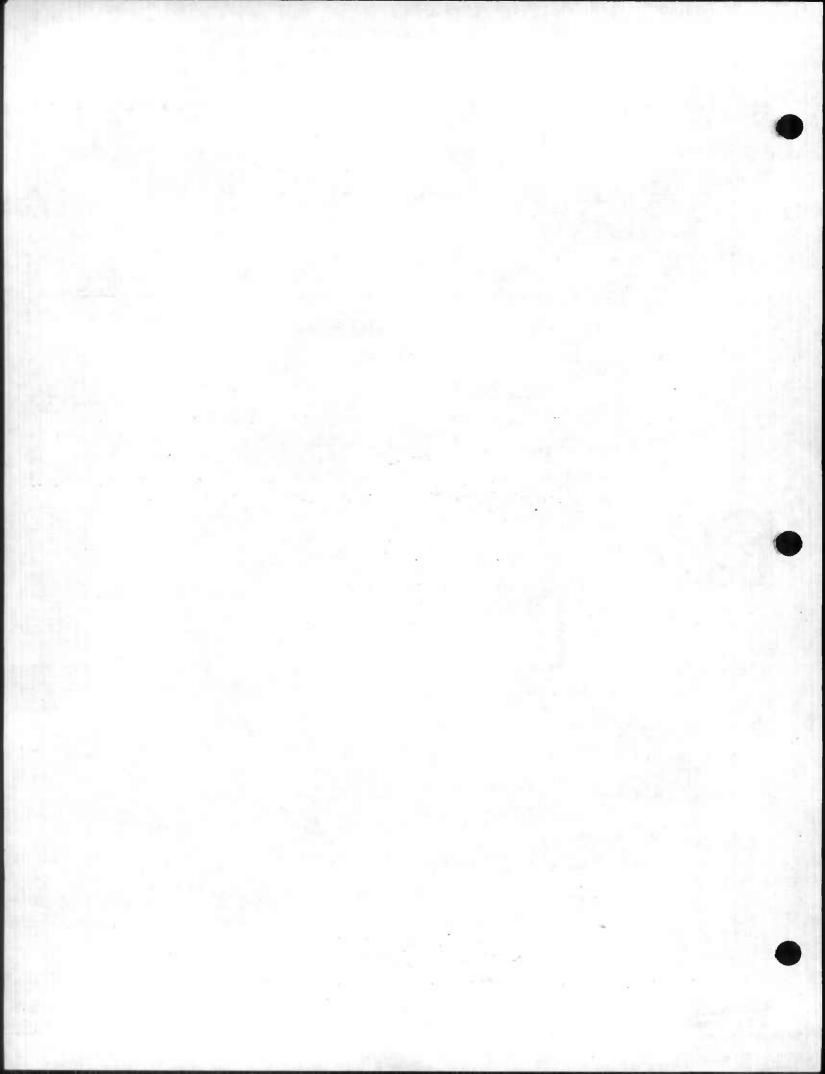
1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** DOROTHY VALENTINE NOVEMBER 3, 2000 4:10PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** ROCKVILLE NURSING HOME ROCKVILLE MONTGOMERY If Undar 24 Hrs. 8. Date of Birth (Month, Day, Yea FEB 27, 1 ff Under 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 79 1921 725 09 3727 Director MASSACHUSETS Usual Residence of Decedent r 28s-f show inotified at 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits the Maryla MD MONTGOMERY GAITHERSBURG 1 ☐ Yas 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iner mat be n 9434 GENTLE CIRCLE USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Nevar Married 2 □ Married 8 Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Black by 3 ☑ Widowed 4 □ Divorced 'natural' the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry 1 and 2 should be filed within College (1-4or 5+) Elementery/Secondery (0-12) Hyglana. FEDERAL GOVERNMENT SECRETARY 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Be Mental PAUL BROWN EMILY MITCHELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ä 9434 GENTLE CIRCLE GAITHERSBURG, MD 20886 CAROL LEDBETTER (DAUGHTER) If Health Item 27 i Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition pemit. Pages 1 Department of Hi Important: If the any injury or oth otice. 1 ☐ Buriel 2 ☐ Cremation 3 MRemoval from Stata 11-9-00 BOSTON, MA CEDAR GROVE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility HINES-RINALDI 11800 NEW HAMPSHIRE 21. Signature of Funeral Service Licenses AVENUE SILVER SPRING, MD 20904 23a. Part1. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical WEEKS CONJESTIVE HEART FAILURE Examiner Due to (or as e consequence of) Examine WEEKS MYOCARDIAL INFARCTION the death certificate be axecuted attending physician and for use es the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): resulting in death) Last signed by the a Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of degth? 1 Yes 2 No 3 Probably 4 Unknown law requires thet Records, by been signature 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has b irector, page 2 s 1 ☐ Yas 2 ☐ No 1 Yes Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After or Attending 5 Pending invastigation 1 Yes 2 No To the Hospital or Attandil within 24 hours after deeth.
To the Funeral Director: A completely filled in by the fu deeth. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Certifier edicai 29b. Signatura and prof certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 20148 MY 11-5-00 2 ours 30. Nama and address of person who completed cause of death (Item 234) (Type, Print) DR. STEVEN DOLINSKY 911 RUSSELL AVENUE GAITHERSBURG, MD 20886 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

mena

NOV 06

2000



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Hattie Janice Whitfield 2000 **October** 29 7:00 p.m. /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1018 Adams Street - Apt. 1D Wicomico Salisbury If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral**  Birthplece (State or Foreign Country) Deys Min 1□M 21 F Months Hours 95 Director 034-16-4837 Dec. 28, 1904 Pennsylvania Usuei Residence of Decedent the Merylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notined at 1X Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1018 Adams Street, Apt. 1D 21804 USA deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Wes Decedent of Hispanic Orlgin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Year or Detes Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglena. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Chepartment of Heelth and Mentel Hyglent Important: if flom 27 is marked other that any Injury or other trauments. Licensed Pratical Nurse (LPN) Boston City Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be unknown Lillie Ingram 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mark Harris/nephew 601 W. 164th Street - New York, NY 10032 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Union UM Church Cemet. 11/4/00 Delmar, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 Part1. Enter the disease, or complications that caused the distrib. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceutly on each line. Approximate intervel Between Onset end Deeth **Physician** Metastatu Cancer of Breast /Medical EUND Immediete Cause (Final disease or condition resulting in deeth) Examiner Examiner thet the death certificate be executed buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last end Due to (or es e consequence ot): physician s the buriel Box 68760 Physician/Medical Due to (or es e consequence ot) for usa es Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 2 No 3 Probably 4 Unknown 1 Yes signed I g 24b. Were autopsy findings evailable prior to completion of cause of deeth? been si 24e. Was en eutopsy performed? Completed paga 2 2 No 1 ☐ Yes 2 ☐ No certificata 1 Yes 25. Wes case reterred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home No No 2 Residence 6 □Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3□ DOA this 28d. Describe how injury occurred To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? Natural 2 Accident 5 Pending Investigation 1 Tyes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Cartifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner as stated.

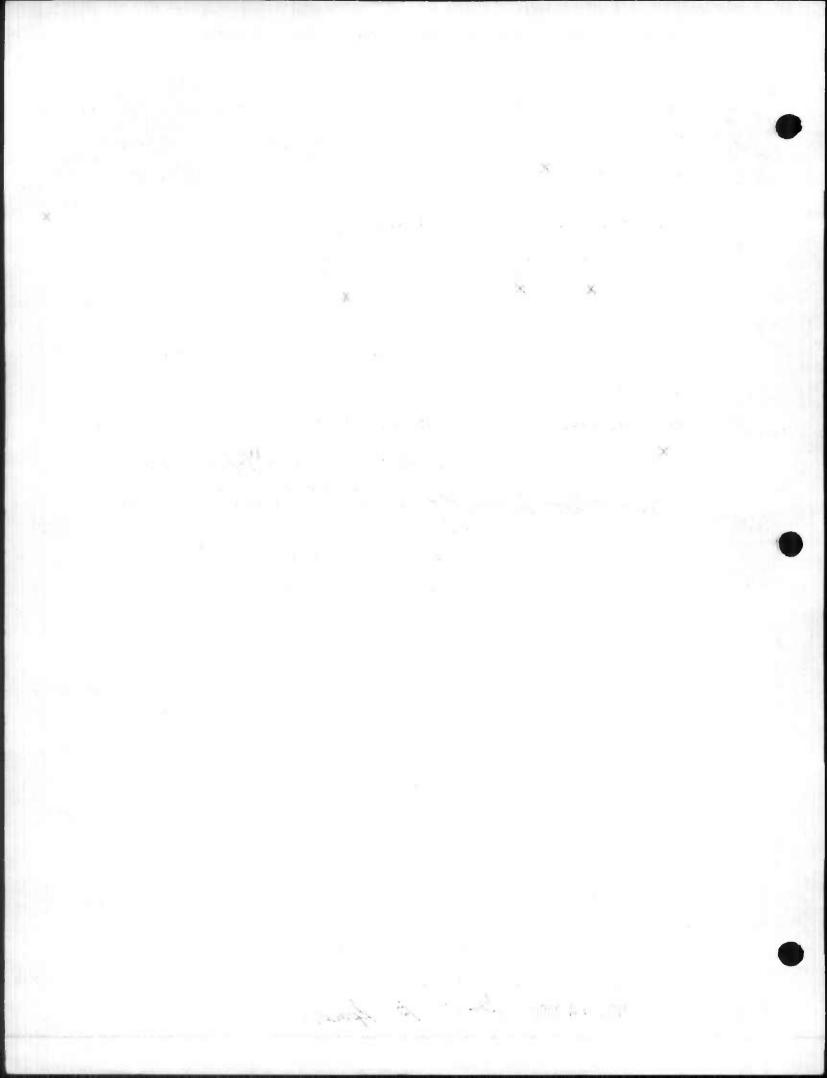
| Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and plece, and due to the cause(s) end menner steted. Medical 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 3mp NOV 2, 2000 Textellation MDess of person who completed cause of deeth (Item 23e) (Type, Print) hristiphn Huddleston- 106 Milford Street - Salisbury MD 31. Date tiled (Month, Dey, Year)
NOV 0 6 2000 32. Legistrer's Signeture State Registrar

DHMH 16 Rav 6/95

NOW THE THE PROPERTY OF MENTALS

State of Maryland / Department of Health and Mental Hygiene [ ] 372

				C	ertificate of	Death	F	leg. No.	9 / 6.	O I
		Decedent's Name (First, Middle, La	st)	11.0			2. Date of Dea	th	3. Tim	ne of Death
Physic /Med		Levin Joseph W	ay SR.				Month Novemb	er 2 2	000 1;	15 AM
Exam		4e. Facility Name (II not institution, giv	re street and number)			4b. City, Town, or	Location of Death	4c. County of		
41.		500 Purnell St	reet			Salisb	ury	Wicon	mico	
Funera Directo		220-28-1004	MA OFF	68 Yrs	Months Days	r If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Apr. 5	1932 I	9. Birthplace (St. Country) Marylar	ate or Foreign 1d
and and		Usuel Residence of Decedent  10e. State 10b. County		10c. City, Town o	r Location				10d Insid	de City Limits
Aaryl sho	5	Manual and VII amus								Yes 2 No
the 1	Director	Maryland Wicomi  10e. Street and Number	.00	Sall	sbury 10f. Zip Code			l0g. Citizen of W		*******
with with	ō	500 Purnell St	root		2180	1		U.S.A	net Country?	
eath m 23	era	11. Marital Status	12. Was Decedent E	ver in U.S.					- American India	n
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, in Medical Evaminar must be notified at once.	by Funeral	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ N If Yes, Give	。 1950–1951	3. Was Decedent of If Yes, specify Cul  1 ☐ Yes 2 No		to Rican, etc.)	Black Specify:	, White, etc.	
2 ho		15. Decedent's Ed	ducation	16a. De	cedent's Usual Occu	pation	1	16b. Kind of Bus		
hin 7	Completed	(Specify only highest gra	Ide completed) College (1-4or 5-	(G	ive kind of work done e. DO NOT use retire	ed) most of wo	rking			
d with	EO	12	College (1-40) 5-		aborer			None		
of He	Be	17. Father's Name (First, Middle, Last,	)			18. Mother's Na	me (First, Middle,	Maiden Sumame	,)	
Alenta Alenta rked tic e	10	Levin Gale				Grace	Way			
sho sho	-	19a. Informant's Name/Relationship (	Type, Print)	19b. M	ailing Address (Stree	et and Number or Ri	ural Route Numbe	r, City or Town, S	State, Zip Code)	
alth alth 27 is		Emma Way (Wife	.)	500	Purnell	Street	Salisb	ury, Md	.21801	
S T E		20a. Method of Disposition		20b. Place of Di	sposition (Name of		Dete		City or Town, Stat	10
Page ent o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		Spring	hill Mem	Carden	11/6/10	Hebron	БМ	
nit. artm orta		21. Signature of Funeral Service Licer			22. Name and Addr	ress of Facility		nebron	, Mu.	
Depa Depa Impo		160	11		Stewart	Funeral				
_		23a. Part . Enter the disease, or com shock, or heart failure. List only	plication that caused		821 West					imate I Between
Physician /Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)	a. META	A STATIC Due to (or as a con	GAS sequence of): HEART	TRIC	CAR	CINOMI		end Death
n #	ner		ANE	=mic	HEART	FAIL	UR E		1	
rtificate be executed ng physician and as the buriel-transit	Examiner	Sequentially list conditions,		Due to (or es e con						
ficate be exemple as the buriel-	m	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury							1	
ate b nysic	Medical	that Initiated events	C	ue to (or as e con	sequence of):				1	
E 0 8	Med								l	
ettending for use a	an		d							
the death ce by the ettendi ached for use	SICI	Part II. Other algnificant conditions of	ontributing to death bu	t not resulting in th	e underlying cause g	iven in Part I.	23b. Dld to	obacco use cont	tribute to the cau	as of death?
d b	by Physician/			-			1 □ Y	08 25 No	3 Probably	4 Unknown
aw requisite been 2 should	Completed						24a. Was a perfor		24b. Were autor available pr completion of death?	rior to
The ate h	NO.						1 🗆 Y	es 20 No	1 🗆 Yes	2□ No
ysician: The lav is certificate has director, pege 2	Be (	25. Was case referred to medical				26. Place of De	ath (Check only or	ne)		
Attending Physician: r death. ector: After this certific. by the funerel director,	10	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpa	tient 3 DOA	ther: 4 Nursing H	lome 5 ☐ Resid	ence 6 Dothe	r (Specify) HO	SPICE
Attending Ph or death. ector: After thi by the funerel		27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Tim				ow injury occurre		
ath. r: After	atio	1 12 Natural 5 ☐ Pending 2 ☐ Accident investigation		roar) Injui		Yes 2□No				
= Q # Q	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, (Specify)	street, factory, office		28f. Location (S City or Tow		or Or Rural Route	Number,
To the Hospital or within 24 hours effe To the Funeral Dir bompletely filled in	edical (	29a. Certifier (Check only one) 1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of niner: On the basis of end manner stat	examination and/or	eath occurred at the t r Investigation, in my	ime, date and place opinion, death occu	o, and due to the corred at the time, o	ause(s) and man late and place, ar	ner es stated. nd due to the cau	ise(s)
within 2 To the Somple	Me	29b. Signature and title of certifier	7			ise number	2	9d. Date signed	(Month, Day, Yes	ar)
P		· cm/1	and)	M·D	D'	50759		11/5/	00	
1 my	8	30. Name and address of person who	completed seven of the	ath /Itom 22a) /T	na Print\			1-1		
1		CHARLES	FO LASTIA	DE, ME	108	50759 PINEB	cuff R	O SAL	TRBMEN	MD 218
St Regist	ate	31. Date filed (Month, Day, Year) NOV 0 6 20	32. Registra	rs Signature	9. doa	,				



State of Maryland / Department of Health and Mental Hygiene 37202

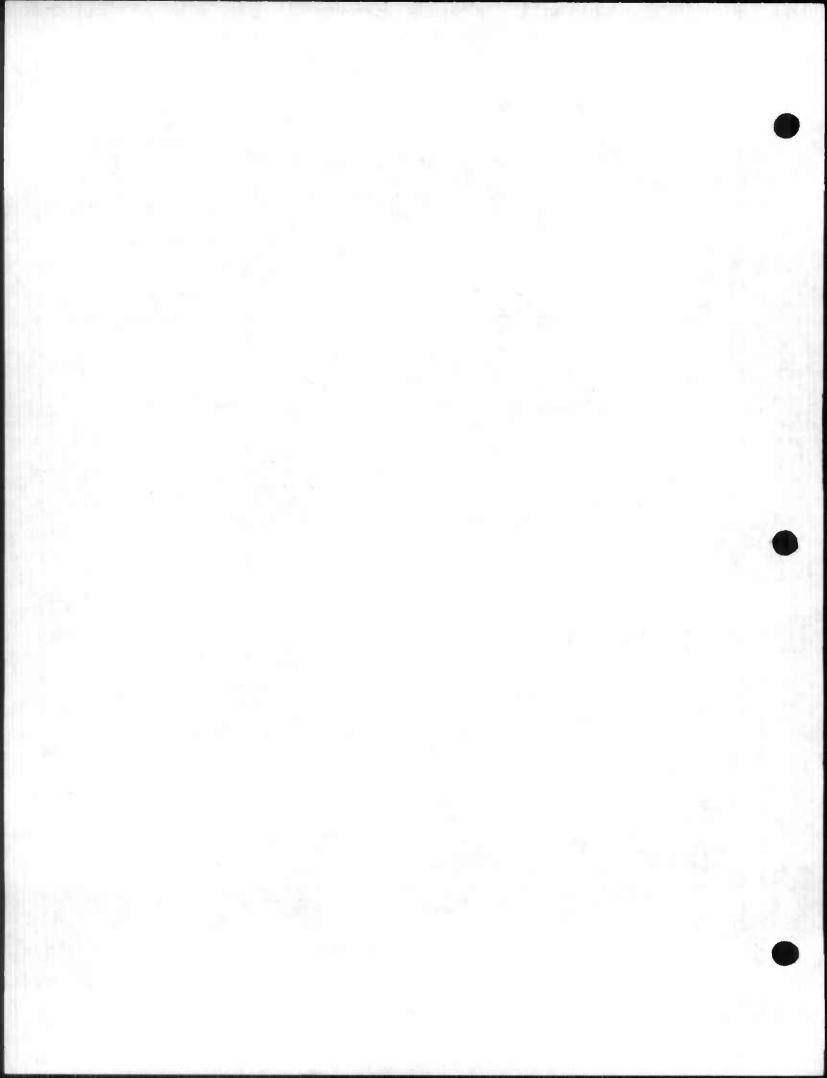
			C	ertifica	te of	Death		Re	g. No.	0	01606
	1. Decedent'a Name (First, Middle, La	st)			E.			2. Date of Deat	h		3. Time of Death
Physician	MARGIE	ROSE	WT	LKINSO	N		1	Month NOVEMBER	R 1, 20	Year	1351
/Medical	4a Facility Name (If not institution, giv		***	DICTION		4b. City. To		ation of Death	4c. County		1331
Examiner				III D							00
	PENINSULA RE  5. Social Security Number 6. S	GIONAL MEDICA	L CENT		er 1 Year	SAI If Under	ISBU 24 Hrs.			COMI	
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S	10e. State 10b. County	10c.	City, Town or	Location						1	0d. Inside City Limit
ath with the Maryla 25e or 25e-f shor sat be notified at ral Director											1♥ Yes 2□N
oct diffe to	MARYLAND WICOMI	CO	SAL	ISBURY							
or 28s-f s be notified Director	10e. Street and Number			10f. Z	ip Code			10	Og. Citizen of V	Vhat Cour	ntry?
6 22 B	401 NEWTON TERRAC	E			2180	1	199		U.S.A.		
her death r thems 23 siner must Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 1	3. Was Dec	edent of H	lispanic Orlean, Mexican	gin? (Spec	cify Yes or No- lican, etc.)		e - Americk, White,	en Indian,
	1 Never Married 2 Married	1 Yes 2 No				Specify:					010.
0 6	3 Widowed 4 Divorced	Year or Dates:		1 1 162	20110	Specify.			Specify	WH	ITE
ed within 72 ho rigene. wer than "nietum it, the Medical. Completed	15. Decedent's Ed		16a. De	cedent's Us	ual Occup	etion			6b. Kind of Bu	usiness/In	dustry
ple ple	(Specify only highest gra	College (1-4or 5+)	life	ive kind of w	use retire	d) mosi	OF WORKIN	g			
the state of	10	College (1-401 54)	HOM	EMAKER	2				OWN	HOME	
	17. Father's Name (First, Middle, Last)				- 00	18. Mothe	r's Name	(First, Middle, N			
ked off c ever o Be	PHILLIP LEF	HODETNO				ET T	7 A D E	OM.	IT T TONY		
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Tage M	ROBERT R. WILKINS		Place of Dis	NEWTO		RRACE	SAI	Date 2			
It of h	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		cometery, c			ce)	I	Date	20c. Location -	City of 16	own, State
Pa mpt my	4 □ Donation 5 □ Other (Specif		COMIC	O MEMO	RIAL	PARK	111	1/6/00	SALISB	URY,	MARYLAND
T Post	21. Signature of Funeral Service Licer	Sem,		22. Name a	nd Addre	ss of Facilit	у	7	05 E. I	MAIN	ST.
Page 18	1 K. K. N	DI C	ESD.	OOIMID		TID AT		T110	CATTO	DIIDV	MD 21804
	23a. Part1. Enter the disease, or com	plications that caused the de						INC.		buki,	Approximate
	shock, or heart fellure. List only	one cause on each line.		011101 1110 1111	, oo o, ay	g, 000				1	Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final	00				1				1	
Examiner	disease or condition resulting in death)	a. (Y)/3	cardi	al F	A	retor	_				7510
			(or as a cons								
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in and intrensit	Sequentially list conditions,	Due to	(or as a cons	sequence of	):						
E PE	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Servi.	1							
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that the delegation of the del								1 TY	9 2 No	3∐ Pro	bably 4 Unkno
2 20 8								04. 186		245 W	are autoesy findings
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hes b										of	deeth?
ate he								1 7 Ye	s 2DNo	11	Yes 20 No
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	examiner? 1 Yes 2 No	Hospital: Inpatient 2	☐ ER/Outpat	tient 2 r	Oth	oer.		ne 5 Reside		er /Soori	(v)
Phy raid raid	27. Menner of Death	28a. Date of Injury	28b. Time		28c. Injui			8d. Describe ho			97
Attending Phor death.  sctor: After the by the funeral of the fune	Natural 5 Pending	(Month, Day Year)	Injur			rk? ∣Yes 2□			, , ,		
is or Attending Programmers after death.  In Director: After the funeration by the funeration:  Certification:	2 Accident investigation 3 Suicide 6 Could not be					100 20		Of Location /Ct	root and Alumb	or or Dur	el Route Number,
or Attendate deat Director:	4 ☐ Homicide determined	28e. Place of Injury - Al building, etc. (Spe	cify)	street, racto	ery, office		-	City or Town		er or num	BI FIGURE INDIFFER
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L hou		ysician: To the best of my k niner: On the basis of exami									
within 24 hours aff within 24 hours af To the Funeral Di completely filled in	one)	and menner stated.		nivosinga iic	··· willy C	Annon, aga	OCCUITE	o at the thine, Ut	oto otto piece,	000 (	0 (.10 02000(0)
Within To the comp	29b. Signature and title of certifier,			2	9c. Licens	se number		2:	9d. Date signe	d (Month,	Day, Year)
10	Valta. 1st	D			145	1619	7		11/2/1	0	
NM	20 Name and address of	nomploted source of death the	om 22a) /T	Deint)	113	0 ( (	(		1190		
	30. Name and address of person who	ompleted cause of death (II	em 238) (1yp	e, Print)	1		(-1	-	MA	711	21
	21 Date filed (Month Day Year)	Residual	11/20	(CK)	ve-t	~ +	JUNI	mon	1.17	218	
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State of Maryland / Department of Health and Mental Hygiene 37203

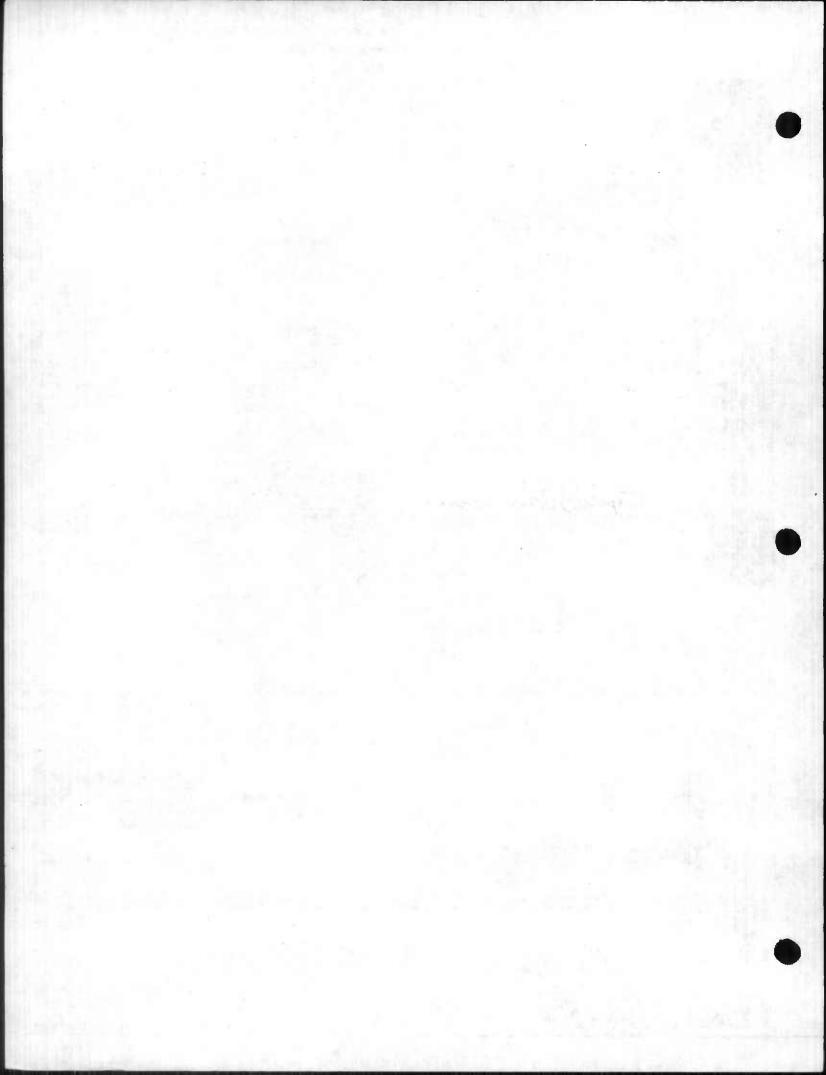
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Physicia		Marjory F.	Weiss						Month	Day	Year	5:05PM	
/Medic Examin	-	48 Fecility Neme (If not institution, give						4b. City, Town, or	NOV. 2, Location of Death		of Deeth	J. UJPM	
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Funeral Director		211 32 0033		ge (In yrs. 82	last birthday Yrs.	Months	1 Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, Da) June 1	, Year) 4, 1918	9. Birthol Count NG	ece (State or Foi try) W York	reign
show	7	Usual Residence of Decedent  10a. State 10b. County Md. Montgome	ery		y, Town or L ethesd					100	10	od. Inside City Li	
with the M 3e or 28e-f	Il Director	10e. Street and Number 7016 Braeburn Pla	ace			10f. Zip	Code 2081	L7	- 1	10g. Citizen of V US	Vhat Count		
CI 21215-0020 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or frems 23s or 28s-f show ant, the Medical Examine. The troubles and	by Funeral	11. Meritel Status  1 Never Merried 2 Married 3 XMidowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	?	,S. 13.	Wes Decedif Yes, special Yes		dispanto Origin? (S en, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	14. Rac Blac Specify	e - America ck, White, e	etc.	
Z1Z15-00Z0 d within 72 hours af glene. er than "natural", or than "natural", or the manage of the ma	Completed	15. Decedent's E (Specify only highest gn Elementery/Secondary (0-12)	College (1-4or	5+)	(Giv.		ork done se retire	during most of word)	1	16b. Kind of Bu		ustry citutes	of
aryland 212 should be filed within and Mentel Hygiene. marked other than imatic avant, the limatic	Be	17. Fether's Name (First, Middle, Last, Morris Fromer	5+		Bloma	thmat	.1CL		ne (First, Middle,			Healt	
2 0 0 0 0	10	19a. Informent's Neme/Reletionship (	Type, Print) Son					end Number or Ru de Dr. Ne				Code)	
Baltimore, M semit. Pages 1 end 2 Separtment of Heelth. mportant: if item 27 it nny injury or other tre		20e. Method of Disposition  1 🗵 Burial 2 □ Cremetion 3 □  4 □ Donetion 5 □ Other (Special		(	Place of Disposemelery, cre	emetory or o	other ple	ce)	Date	20c. Location -			a.
Baltimo permit. Page Department of important: if any Injury or		21. Signeture of Funeral Service Licer		- 10		22. Name ar Edwar	nd Addre	ess of Facility agel Fune sville Pi	ral Dire	ection,	INC.		
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Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)	a. Col	on		er						Onset end Death	
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od by th	by Physician/M	Pertil. Other significant conductis o	Ontributing to death 2	out not res	ulling in the	underlying c	ause gr	vertin Perti.		Yes 2 No	3 Prot		
Of Vital Records, Physician: The law requires this certificate has been signs ral director, page 2 should be	Completed b				200		8			en eutopsy med?	ave	ore autopsy lindir bileble prior to npletion of cause death?	
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		30. Neme and address of person who	completed cause fold				Sin D	he suk 2	14 Chem	CUAR IN	). Zee	505	
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State of Maryland / Department of Health and Mental Hygiene

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ledical	45	Facility Name (If not institution,			IIIams			lb. City, Town, or I	1	er 7, 2		0:25 AM
miner		4116 Farragut		um <i>ber)</i>				Hyattsv			ce Geo	rge's
eral tor	5. 5		6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs 43	last birthdey Yrs.	Months		If Under 24 Hrs. Hours Min.		th y, Year)		(State or Forei
	1	ual Residence of Decedent		140-0							1004	
uneral Director		a. State 10b. County			ity, Town or L							Inside City Limit  1   Yes 2   N
Directo		aryland Prince	George'	S			_	ville		10 000 11		
		4116 Farragut	St.			10f. Zip		20781		10g. Citizen of United	State:	
by Funeral		. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ☐ Widowed 4 ☑ Divorced	Armed F	2 No live	J,S. 13.	Was Deced If Yes, spec		ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, efc.)	14. Rad Bla Specif	ck, White, etc.	
Completed		15. Decedent's (Specify only highest	grade completed		16a. Dece (Give life.	edent's Usue e kind of wor DO NOT us	el Occup rk dorie d se retired	ation during most of wor	king	16b. Kind of B	usiness/Indust	ry
mo:		Elemantary/Secondery (0-12)	5+	(1-4or 5+)	P	rofess	sor			Higher	Educat	ion
Bec		. Father's Name (First, Middle, L	ast)					18. Mother's Nar	ne (First, Middle,			
10		Ronald		Wi.11	iams			Arlene		Ε.	Ha	rris
100	19	a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mail	ling Addrass	(Streat	end Number or Ru	iral Route Numbe	er, City or Town	, State, Zip Co	da)
		Arlene E. Willi	ams / Mo					gan Ave.	#1511;			0605
	200	e. Method of Disposition  1 □ Burial 2 ☑ Cremetion	3 DRemovel from		Place of Disp cemetery, cre	osition (Ner emetory or o	ne of ther piec	e)	Nov. 8	20c. Location	- City or Town,	State
		4 Donation 5 Other (Spe			-			ory Inc			ille,	MD
- Aller	21	Signature of Funeral Service L	Lati		2	Rapp Stepl	Fun hen	ss of Facility and eral and D. Lohrm	Cremati ann P.A.	on Serv	ices	210
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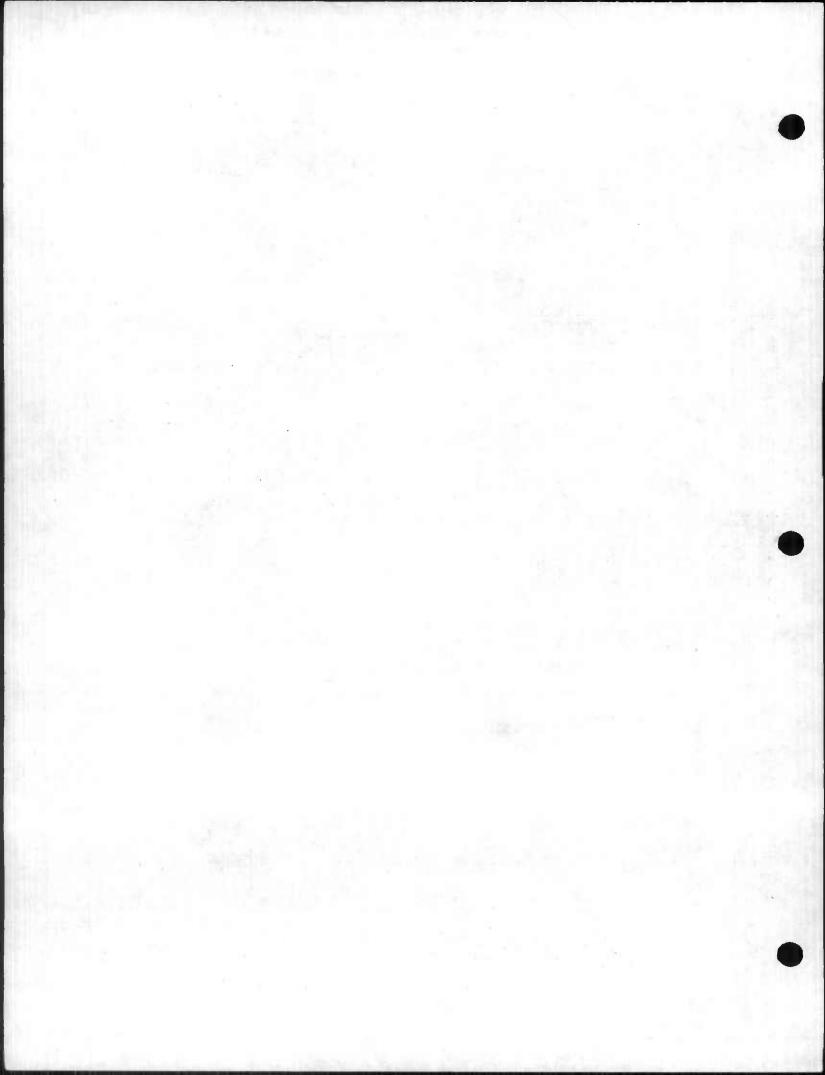
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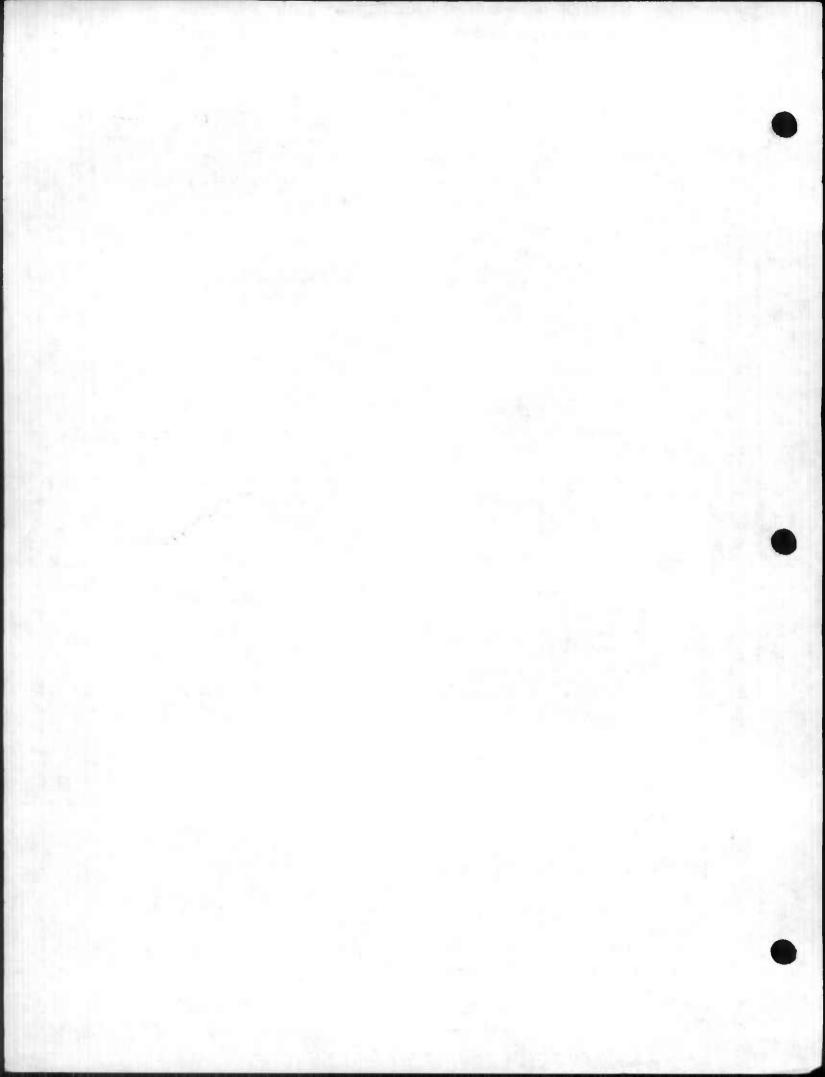
		-41	Cei	rtificate of	Death		g. No.		Total of Death
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/Medical	- F- W- Al		se wortan	.u	4b. City, Town, or L				:15 PM
Examiner	4a Facility Neme (If not institution, given 5212 Goddard Ro					ocation of Death	4c. County		
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Funeral Director		□M 2√2 F	90 Yrs.	Months Deys	Hours Min.	8. Dete of Birth (Month, Dey, April 30	, 1910	Country) Virgin	(State or Foreign
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o Me a Me	Maryland Montgo	nery	Bethesd	a				_4_	1 ☐ Yes 2√∏ No
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23e vant	5212 Goddard Road				0814			ed Stat	
# 22 5	11. Meritei Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	or No- 14. Raca - Am Bleck, Whi Specify: Wh		ndien,
nemit. Pages 1 and 2 should be filed within 72 hours at operations of operations of operations of operations of operations of the marked other than "natural; or my injury or other traumetic event, the Medical Examples."  To Be Completed by F	15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12)	fucation de completed) College (1-4or 5+)	16a. Dece (Give life.	DO NOT use retire		ing	16b. Kind of Bu	usiness/Industr	гу
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2 should be and Mental is marked in marked in To B	George Pauly				Rose Ju		20 115		
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and 2 hasith a m 27 is her trau	Kathleen W. Hamm/		5212 20b. Plece of Dispo		Road, Bet				
Pages ent of ) ny or of	20a. Method of Disposition 1 ☐ Buriel 2 ☒ Cremetion 3 ☐	Removel from Stete	cemetery, cres	metory or other ple	1	Nov 7	20c. Location -	City of Town,	216/g
Part Part	4 Donetlon 5 Other (Specif		Montgomery			2000	Bethesd	a, Mar	yland
Demili Depart Import any in	21. Signature of Fureral Service Lices		01126 Be	thesda-C	ess of FacilityRob hevy Chas Maryland	e, Inc., 7	557 Wis		
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Physician /Medical Examiner	Immediate Cause (Final disease or condition	Cerebrov	ascular A	Accident					8 Hours
je je	resulting in death)	Du	e to (or es e consec	quence of):			1 1		
icate be assected physician and is the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	e to (or as e consec	quence of):				1	
7	resulting in death) Lest	d	e to (or es e consequenca of):						
. 5 .5	Pert II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause gi	ven in Pert I.	23b. Did to	bacco uae co	ntribute to the	cause of death
d by Setac	Senile Dementia					1 🗆 Ye	es 210 No	3 Probebl	y 4 Unknow
aw requir us been s 2 should pleted						24e. Was e	n eutopsy ned?	availat	autopsy findings ble prior to etion of cause th?
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B Age of	27. Manner of Death  1 Natural  2 Accident  1 Natural investigation		(ear) 28b. Time o	Wo	nyat ork? ]Yes 2 □ No	28d. Describe ho	ow injury occur	red	
affer death. I Director: Affer death. I Director: Affer death. Certification	3 Suicide 6 Could not be determined	28e. Place of injury building, etc. (	- At home, farm, str Specify)	reet, fectory, offica		28f. Location (St City or Town		per or Rurel Ro	oute Number,
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Withir To th	29b. Signeture and title of pentiller	2. //			se number		9d. Dete signe		
5	> Pelevi	Han	m		32033	N	Novembe	r 3, 20	000
	Peter G. Hamm, M.	D. 5454 Wi	sconsin A		Suite 1125	, Chevy	Chase,	Maryla	and 2081
State Registrar	31. Dete filed (Month, Dey, Year) NOV 06 2	32. Registrer's		spork.					

DHMH 16 Rev 6/95



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neral ector			Sex 7. Age 1	(In yrs. last bin	Yrs. If Under Months	r 1 Yaar Days	If Under 24 Hrs. Hours Min.		h /, Yeer)	9. Birth	pleca (Stete or Fore
A 4	-	Suel Residence of Decedent  Oa. State 10b. County		10c. City, Town							10d. Inside City Lin
cto roto		MO Bal	timore	Per	rry Hall	L					1 ☐ Yes 2 ☒
tems 23s or 23s-f show from must be notified at Tuneral Director	10	0e. Street and Number 56 Laurel Path	Court		10f. Zi	p Coda 2123	36		10g. Citizen of 1	What Cou	ntry?
by by		Marital Stetus     Never Married 2 Married     Widowed 4 □ Divorced	12. Was Decedent E Armed Forcas? 1 Yes 2 XN If Yes, Give Yeer or Detas:				lispanic Origin? (Sp an, Maxican, Puarto Specify:	pecify Yas or No- Rican, etc.)	14. Rad Bla Specifi	ck, White,	ican Indian, , etc. nite
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erked other than etic event, the To Be Comp	17	7. Fathar's Nama (First, Middle, Las					18. Mother's Nem		Maiden Suman	ne)	
To To		Richard Arczyns					Susan F				
E E E	1	9a. Informant's Name/Reletionship	(Type, Print) moths	ar 19b	. Mailing Addres	s (Street	and Number or Ru	ral Route Numbe	r, City or Town	State, Zij	p Code)
-	20	Susan Arczynski  De. Method of Disposition  1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Spec	Removal from State	20b. Place of	Disposition (Nerry, crematory or	me of	ch Ct., B	altimore Date 1/25/00E	20c. Location	- City or T	own, State
Important: If any injury or once.	2	1. Signature of Funeral Service Lice	Dannen	0			ss of Fecility Jo Conkling				
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sician		shock, or heart failura. List only	y one cause on aech iin	в.							Onset end Death
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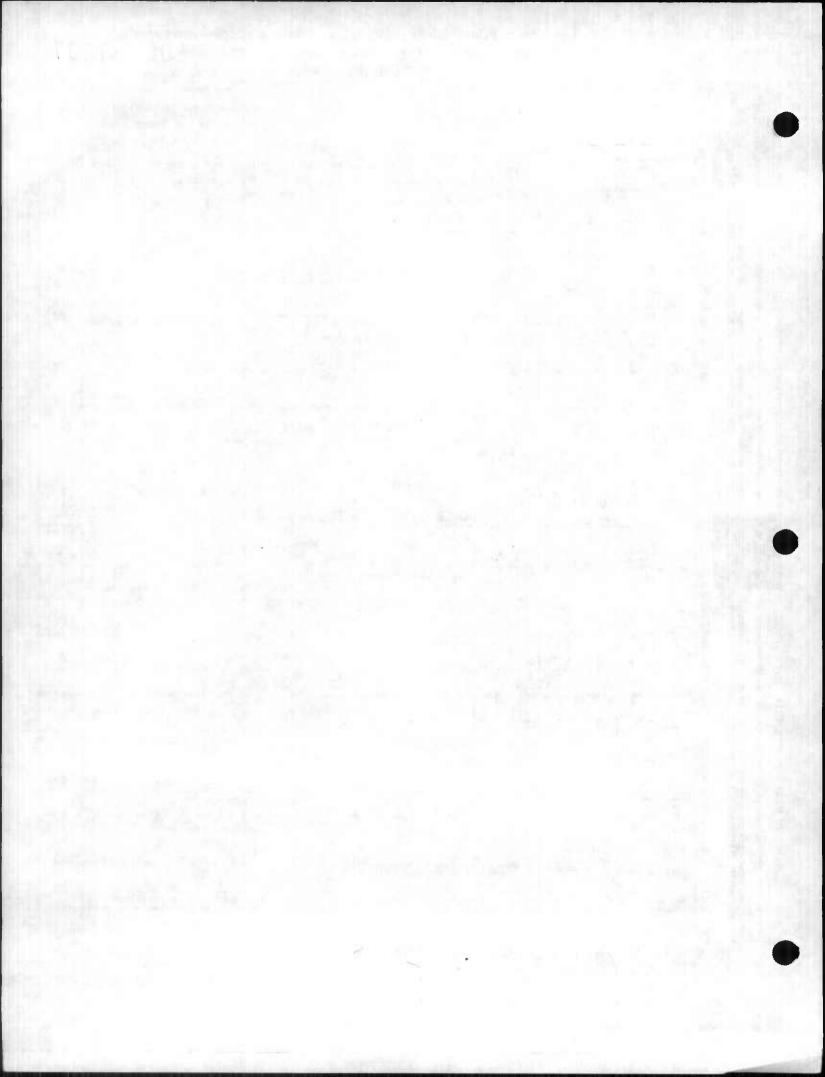
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			634 Overbrook Ro	ad			21212			United S	tates	
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e c	が見る		20a. Method of Disposition	10 16 O	20b. Pl	ace of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location - 0	City or Town, State	
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		+	23a. Part 1. Enter the disease, or com	plications that caused	the death	. Do not ent	er the mode of dy	ing, such as cardi	ac or respiratory a	rest,	Approximate	
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Rox	attanding	Physician/M		d								
Ď	atta d for	20	Part II. Other significant conditions of	ontribution to death by	ut not resu	iting in the u	nderlying cause di	iven in Part I	23b. Did	tobacco use con	tribute to the cause of	death?
<b>9</b>	ch the	S T			1			NON MIT WITH		Yes 2 No		nknown
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2	v requires that been signed b should be dete		1							an autopsy ormed?	24b. Were autopsy find available prior to	dings
Hecord	law requias been 2 shoul	Completed								Jimou.	completion of cau of death?	ISO .
	The law ate has page 2	E							10	Yes 20 No	1 ☐ Yes 2 ☐ No	0
	certificate ha irector, page	Re C	25. Was case referred to medical					26 Place of D	eeth (Check only			
>		0	examiner? 1 Yes 2 No	Hospitel:	ant 2 🗆 I	ER/Outpatier	N 3 DOA O	ther:	Home 5□ Res	S	r (Specify) Hosp	ice
	After this funeral of	=	27. Menner of Death	28a. Date of Inju	ry	28b. Time of			1	how Injury occurre		
0	ith. : After e funer	200	1 Netural 5 Pending 2 Accident investigation	(Month, Da	y rear)	Injury		Yes 2 No				
DIVISION	or Attending after death. Director: After I in by the fune	100	3 ☐ Suicide 6 ☐ Could not b	200. Place of inj	ury - At ho	me, farm, str	eet, factory, offica				er or Rural Route Numbe	91,
_	after Direct din by	Certification:	4 Homicide	building, et	c. (Specify	)			City or 10	wn, State)		- 1
				ysician: To the best								
	Fur letaly	edicai			examinet						nd due to the cause(s)	
	within 2 To the comple	Z	29b. Signature and title of tertifier	1.1	2			se number			(Month, Day, Year)	
	0		Dell thath	millil	en	us	Da	25205		Noven	ber 20 8	2000
	1	-	30. Name and address of person who	completed cause of	nati (Itam	23a) (Type	Print)	0	0 0:		/	
			W.A. Riley	Gund	670	1 N.	Charle	o St.	Bolto.	md 2	ber 20, 3	
	State	9	31. Date filed (Month, Day, Year)	32. Registr	ar's Signat		4					
	Registra		NOV 2 7	2000	corres	v /	Kno	10				
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DHMH 16 Rev 6/95

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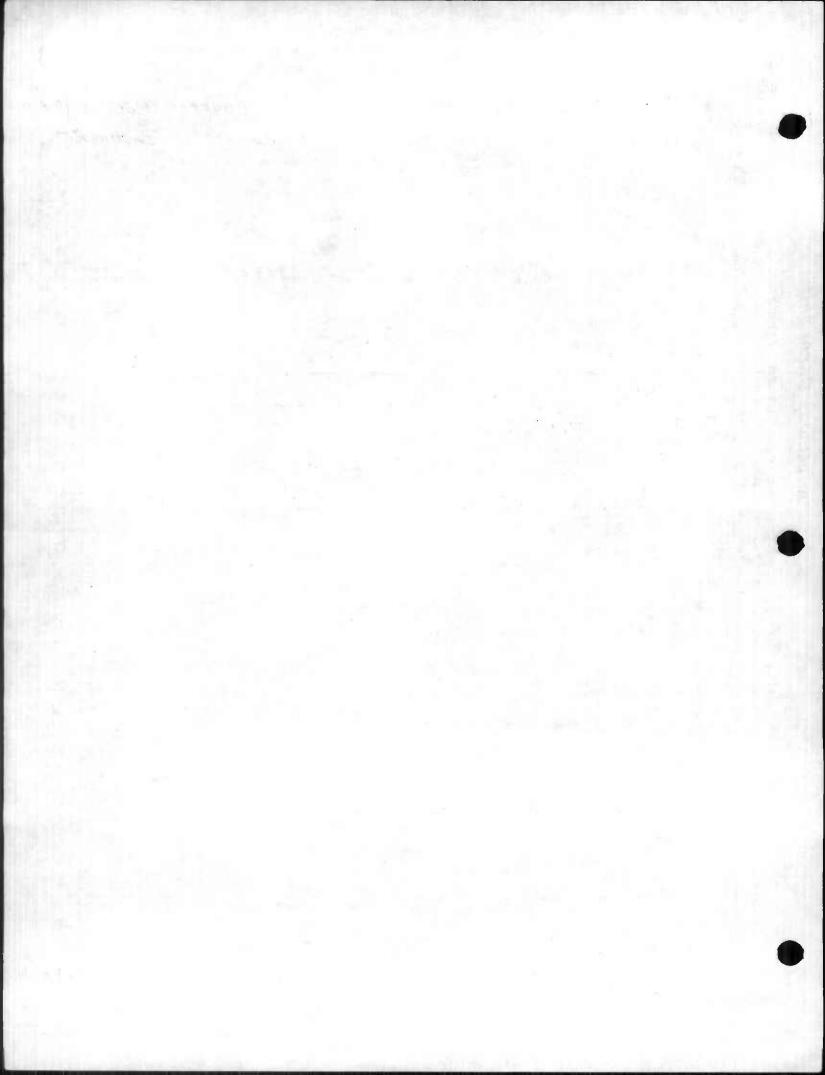


			Certificate of		Reg. No.	00 37208
Physician	1. Decedent's Nama (First, Middle, L		ndrews	/M	ata of Death onth Day	3. Time of Death
/Medical	Geraldine 4a Facility Name (II not institution, g		100 EWS	4b. City, Town, or Location	VEMBER	17 2000 8:40 A.m.
Examiner	FRANKLIN SQUA	4	CENTER	ROSEDALE		BALTIMORE
uneral		Sex 7. Age (In yrs. I			ate of Birth lonth, Day, Year)	Birthplace (State or Foreign Country)
rector	232-42-5766 Usual Residence of Decedent	1□M 2DXF 73	Yrs.	12	2/29/192	26 Lost Creek W
28a-f show notified at	10e. State 10b. County		, Town or Location		5756	10d. Inside City Limits 1 ☐ Yas 2 ☐ No
be notified at Director	MD Baltin	ore Wh	ite Marsh	•	10a Citiz	en of What Country?
2 6						
Funeral	11623 Jerome A	12. Was Decedant Evar in U.		L 162 of Hispanic Origin? (Specify Y		JSA 4. Race - Amaricen Indian,
by Fun	1 Never Married Married 3 Widowed 4 Divorced	Armad Forces?  1 Yas 2 No If Yas, Give Year or Datas:	If Yas, specify C	of Hispanic Origin? (Specify Youban, Mexican, Puerto Rican No Specify:		Black, Whita, etc.  Specify: White
	15. Decedant's (Specify only highest g	ducation	16a. Decedent's Usual Oc	cupation	16b. Kin	nd of Business/Industry
rt, the Medical	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)	Dietary Technici	na during most of working tired)	Emple	Lin Square Hosp.
ပိ	17. Father's Name (First, Middle, Las		bletary learner	18. Mother's Nama (Firs		
To Be	Edward Carl (			Flora Gib		
-	19a. Informant's Name/Relationship		19b. Mailing Address (Str.	eet end Number or Rural Rou		Town, Stata, Zip Code)
	Brenda Sobczyr	ski	11623 Jero	ome Avenue W	hite Ma	arsh, MD 21162
r other traumatic event,	20a. Method of Disposition		lace of Disposition (Nema or	Da		cation - City or Town, State
ary or	1 Donation 5 Other (Spec		Air Memorial Ga	ardens 11/20	/2000 BelAi	ir. MD
any injury or other traumatic event, in page.  To Be Co	21. Signature of Funeral Service Lice			dress of Facility In Funeral Home I		
2 9	Cetter (19	Sho Charock:		lair Road Kingsvi		and 21087
	23a. Part1. Enter the diseasa, or co shock, or heart failure. List on	nplications that caused the death				Approximata Interval Between
an				0 1.		Onset and Death
cal ner	Immediate Cause (Final disaasa or condition resulting in death)	My	ocardial 1	infarction	1.00	hours
	resulting in death)	Dua to (or	as a consaguance of):			-10
Examiner			xucholestero	iemia		171011015
-	Sequantially list conditions,		as a consequence of):  Our tension			>10ycars
×	if any, leading to immediata		I WW LE WALL			
	if any, leading to immediata cause. Enter Undarlying Cause (Disease or Injury	·				11092005
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	if any, leading to immediata cause. Enter Undarfying Cause (Disease or Injury that initiated evants	Due to (or	as a consequence of):	given in Part I.	23b. Did tobacco t ☐ Yea 2[	use contribute to the cause of death?
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Registrar

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State Registra

29b. Signature end title of certifier

31. Date Hed (Menthy Days Year)

SOONE

**DHMH 16 Rev 6/95** 

ny

32. Registrer's Signature

30. Nama and eddress of person who completed cause of deth (Item 23e) (Type, Print)

Millin

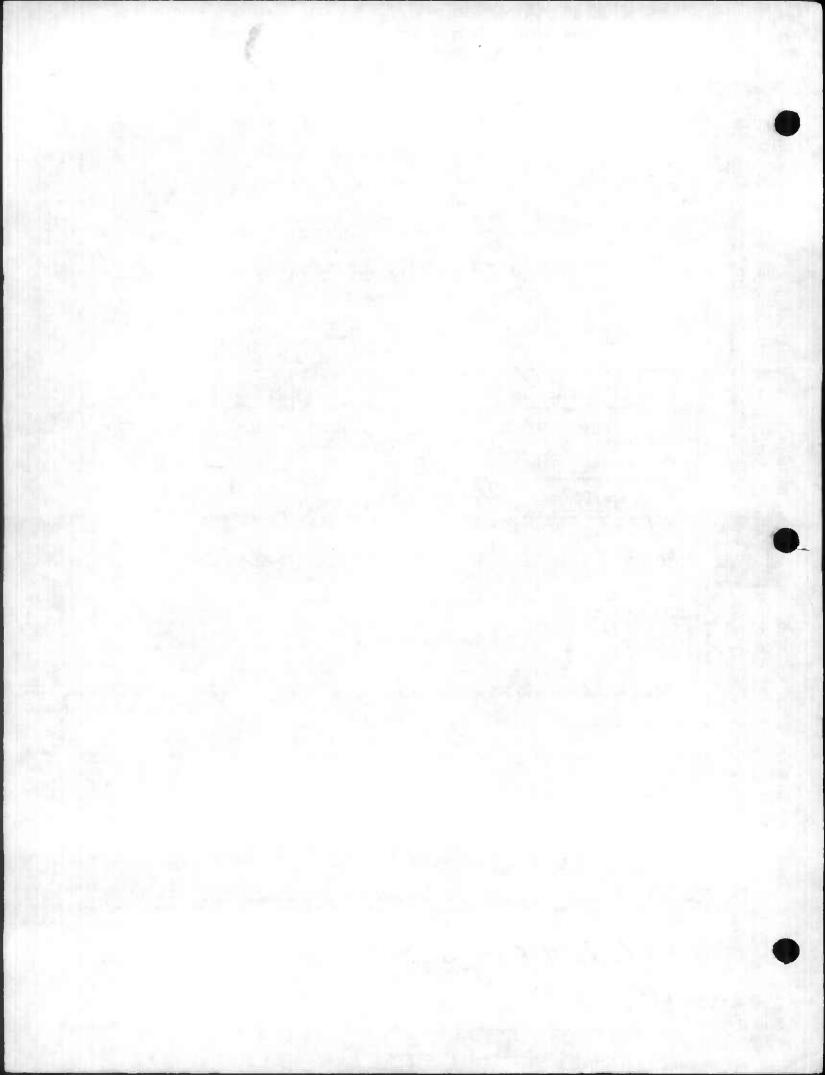
29c. License number

OCME

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

NOVEMBER 21, 2000



# **Funeral** Director

21215-0020

0

/Medical Examiner 23a or 28a-f show Director Funeral death or items 72 hours after þ "natural"

Pages 1 and 2 should be and l Health I Baltimore, 8 Department of important: If any injury or anse. Physician /Medical Examiner

The law requires that the death certificate be executed Box 68760. use as the P.O. of Vital Records. page 2 should be this certificate has Division

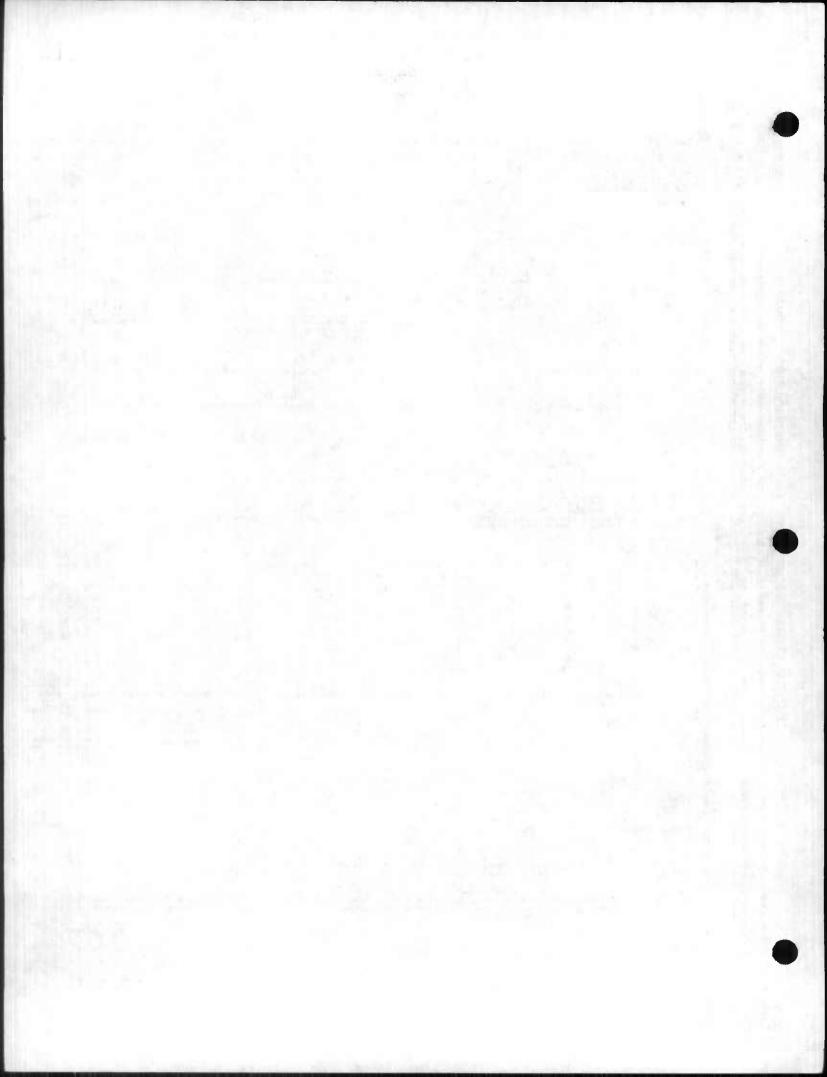
Certificate of Death 2. Data of Death 1. Decedent's Name (First Middle Lest) 3. Time of Death **Physician** 515 PM Frances L. Barbieri November 21 2000 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street end number) Center Baltimore Franklin Square Hospital Rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)

Months Days Hours Min. 9-7-08 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 □ M 250 F Yrs. Italy 217-32-7749 Usual Rasidence of Decedant 10a. State 10c. City, Town or Location 10d. Insida City Limits 10b. County the Medical Examiner must be notified at 1 Yas 2 No Rosedale MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10a Street and Number USA 21237 1515 Weyburn Road 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Own Home 3 0 Home Maker 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) nd Mental I Seminaroti Maria Dominic Procopio 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnforment's Name/Relationship (Type, Print) 1513 Customs Road, Baltimore, MD Catherine Johnson/Daughter 21237 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery 11-25-00 Baltimore, MD 22. Nama and Address of Facility 21. Bignature of Funeral Service Licens Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each lina. Approximate Interval Between Onset and Deeth Immediete Cause (Final disaase or condition resulting in death) · Preumonia Due to (or as a consequence of): Examiner Respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of). Physician/Medical Dua to (or as a consequenca of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 00 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) 1□ Yes 2000 Hospital: 1 Dopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Athor or Attending 5 Pending investigation 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Roule Number, City or Town, Stete) 4 Homicide within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

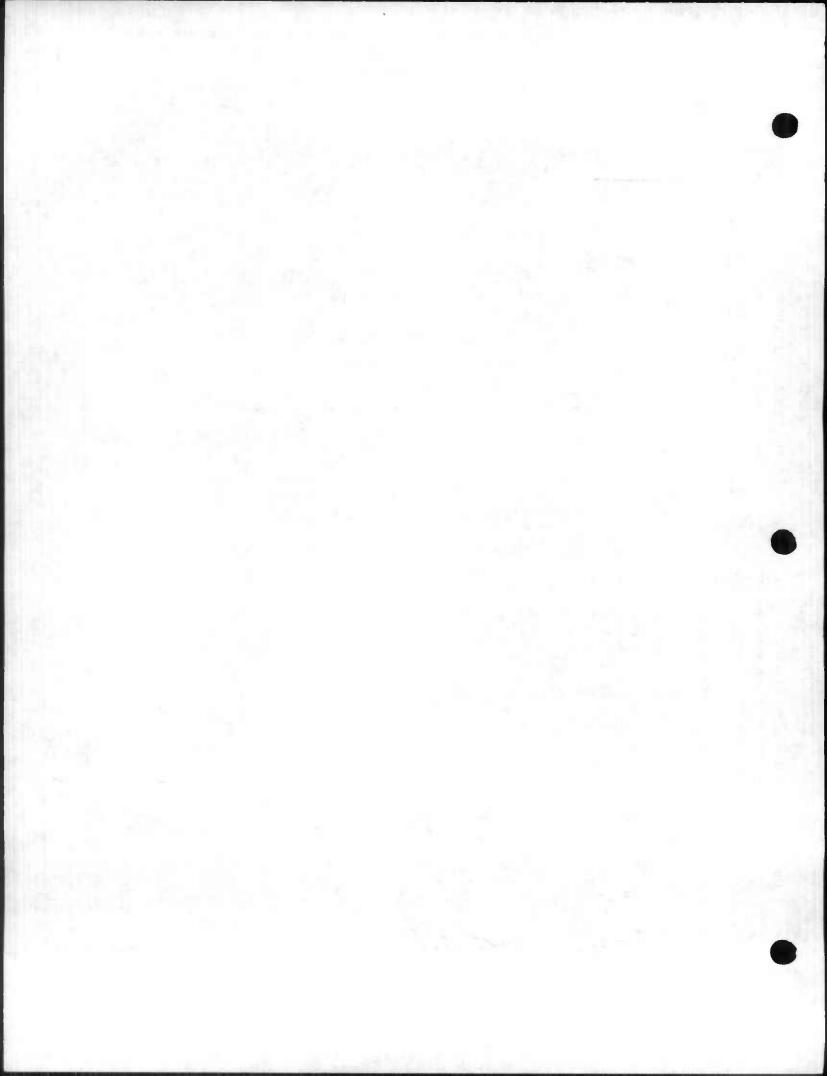
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29e. Certifier Medical (Check only one) and mannar stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bull ~ no le 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore Maryland DR Michelle Boswell 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State NOV 2 7 2000 Registrar

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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er		t Jose				ter		Tov	son			timore
	5. Social Secur	rity Number	6. Ser		7. Age (In yrs	. last birthdey)	If Under 1 You Months De	eer If Under 24 eys Hours	Hrs. 8. Date of	Birth Dey, Year)	9. Bir	thplece (State or For
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		m A. Bu				19b. Mailing	a Address (St	reet end Number o	hel Myer	S mber, City or 1	Town, Stete	Zip Code)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 4:46 PM 2000 Berry Lucille 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) IEN B ARUNDEL NORTH If Undar 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (in yrs. last birthday) Days Hours 1□ M 200 F 236-40-5189 23,1928 W. Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8177 Bodkin Ave U.S.A. 21122 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Datas: 1 Never Married 2 Married 1 Yes 2 No Specify 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Social Security Admin. 12 N/A File Clerk 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8177 Bodkin Ave Pasadena, Maryland 21122 Donald E. Berry (Son) 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cramation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park 11/27/00 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Part I nier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. Approximate Interval Betw Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

/Medical Examiner Box ( P.0. Records,

of Vital

Division

Examiner this

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at

Pages 1 and 2 should be nent of Health and Mental

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once.

**Physician** 

Director

Funeral

by

Completed

Be

Hospital or Attending Physician: 24 hours after death. Director: /

Physician/Medical Be Completed by

edical Certification: To

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 4 - Homicide

29a Certifier

Investigation 6 Could not be determined

5 Pending

28a. Date of Injury (Month, Day Year) 28b. Time of

Injury 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28d. Dascribe how injury occurred

DASADENA, MC/21122

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner as steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and attinual certifies

29c. License number 031322 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. PRADEEC GAROM U304 M71 GARGIMO 4304 MTN. RD.

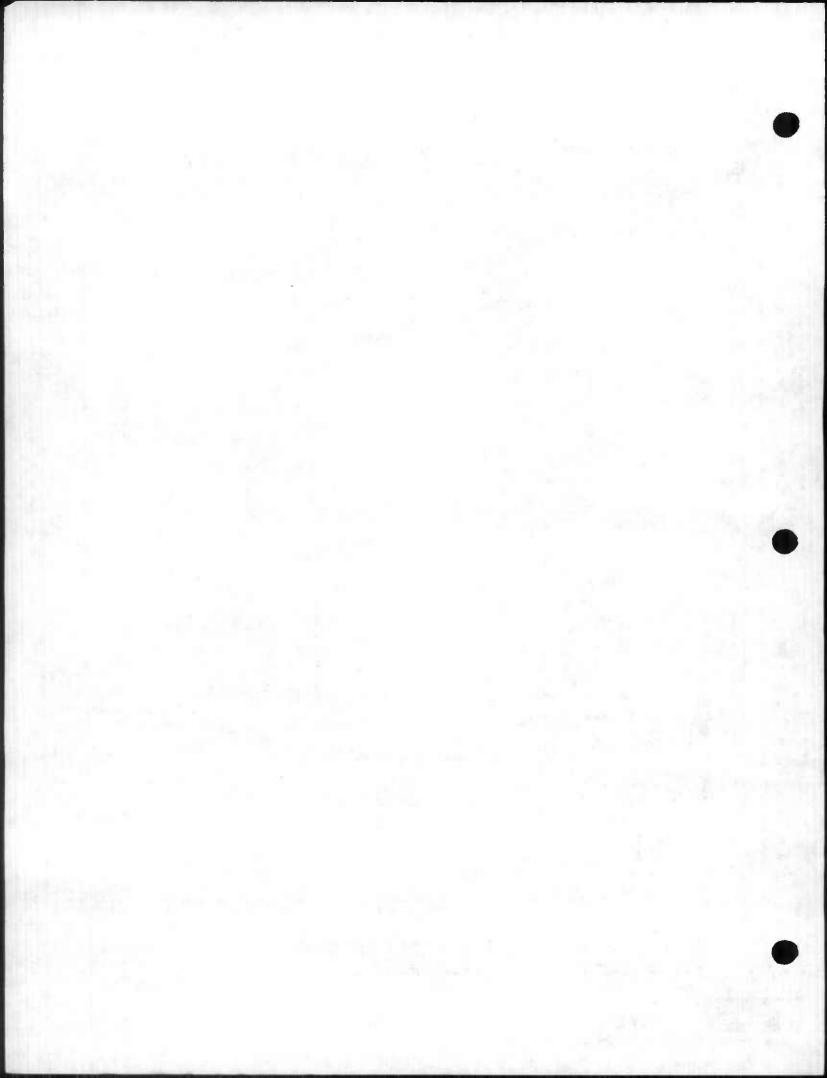
31. Date filed (Month, Day, Year) State

2000

32. Registrar's Signatura

Registrar

To the Hospital or A within 24 hours after To the Funeral Dire completely tilled in b



Registrar

Shakunmala 31. Date filed (Month, Day, Year) NOV 2

29b. Signature and title of certifier

fuple

2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLI'M SEULRE DR BALTIMORE MARYLAND Gupla 32. Registrar's Signature

29c. License number

D0053150

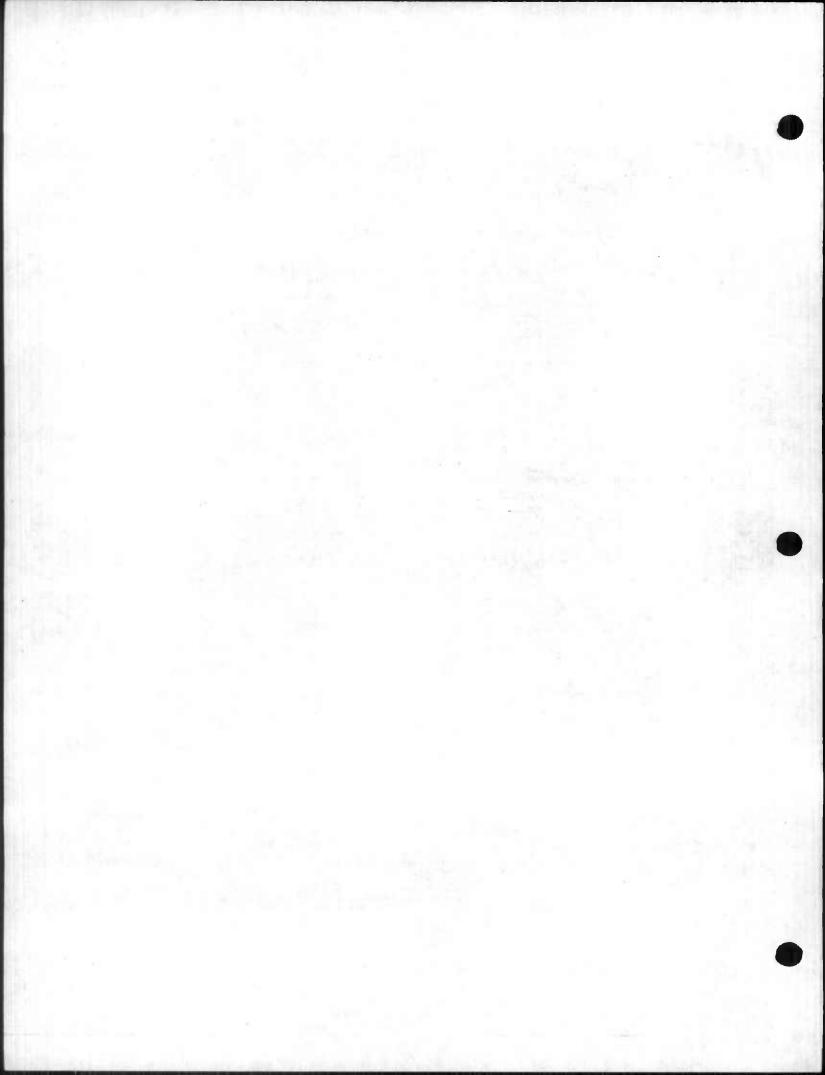
29d. Date signed (Month, Dev. Year)

NOVEMBER

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**DHMH 16 Rev 6/95** 

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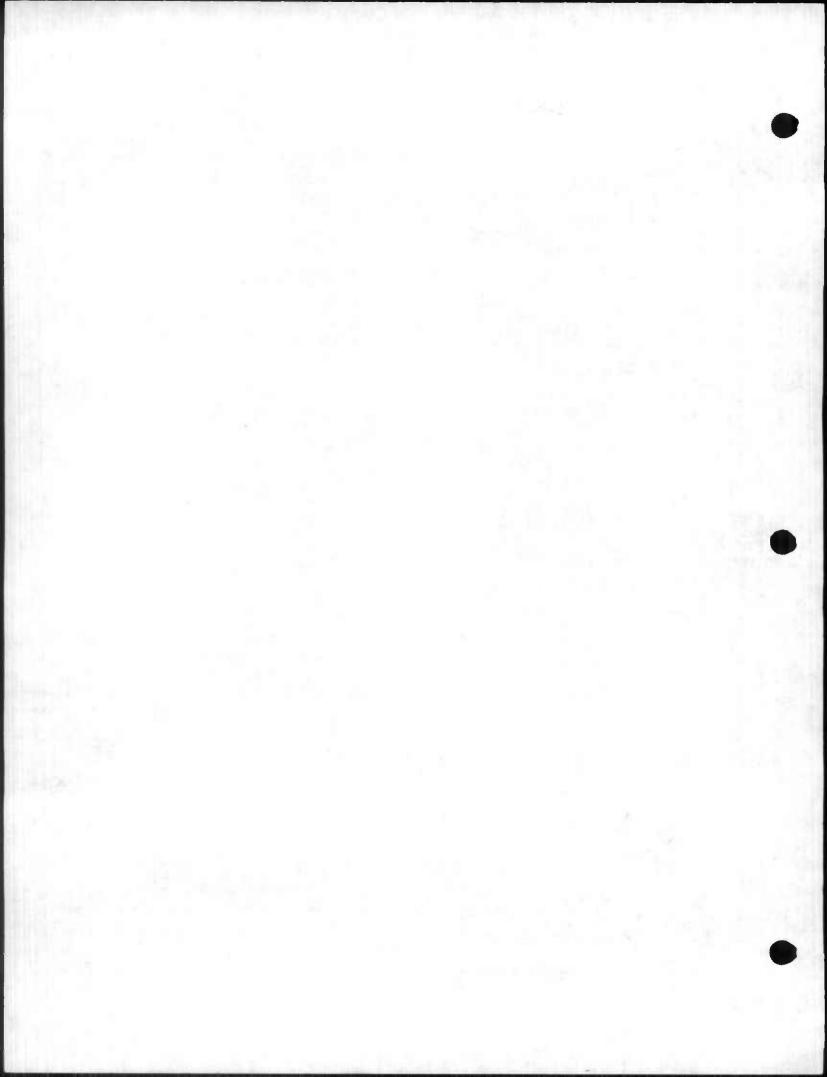


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/Medical	NORA MARIE BRE 4e Fecility Neme (If not institution, give	Street and number)			4b. City, Town, or Lo	VEMBER cation of Death	25. 2 4c. County	@@@  @3:45 A
Examiner	Saint Joseph M		ter		Towso			altimore
Funeral Director	5. Sociel Security Number 6. Se 220-10-2282	x 7. Age (In yrs	s. lest birthdey) If Ur Yrs. Mont	hs Deys	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, De) September	18,1915	9. Birthplece (State or Forei Country) Ireland
Du B	Usual Residence of Decedent  10a. Stete 10b. County	10c. C	City, Town or Location					10d. Inside City Limi
Manylar 4 show			monium					1□Yes 2√N
with the Mar ta or 28a-f al Los notified	10e. Street and Number 2300 Dulaney Valley Roa			Zip Code 21093	3		IOg. Citizen of W	
Maryland 21215-0020  4 2 should be filed within 72 hours after death with the Maryland th end Mental Hygiena. 7 is marked other than "natural", or items 23a or 28a 4 show traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yas 2(W) No If Yes, Give Yaar or Dates;			Hispanic Origin? (Spe pen, Mexicen, Puerto	ecify Yes or No- Rican, etc.)		e-American Indian, k, White, etc.
5-0 72 ho	15. Decedent's Edu (Specify only highest gred	cetion le completed)	16a. Decedent's l	Isuel Occu	pation during most of worki	na	16b. Kind of Bu	siness/Industry
nd 21215-0 of filed within 72 ho all hygiena. I other than "nature yvent, the Medical.	Elementery/Secondery (0-12)	College (1-4or 5+)	life. DO NO	T use retire	ed)			
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Maryla d 2 should the and Ment T is marked traumatics	19a. Informant's Name/Relationship (T)	rpe. Print)	19b. Meiling Add	ress (Stree	t end Number or Rure		r, City or Town,	State, Zip Code)
C = N L	Frank Gallagher	Lawyer			Vay Baltimore		-	
0 - £ E 4	20e. Method of Disposition  1) We Burial 2 Cremation 3 F  4 Donetion 5 Other (Specify)	Removal from State	Place of Disposition cometery, cremetory	or other ple		Dete 2/2/00 :	20c. Location -	City or Town, Stete
Baltimo pemit. Pege: Department of important: if it any injury or once.	21. Signeture of Funerel Service Licens			end Addre		chell-Wie	edefeld Fu	uneral Home Inc
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r Vital Pysician: The scentificate director, pag	25. Wes cese referred to medicel examiner?				26. Place of Deet	(Check only o	ne)	
Of VITA Physician: this certific ral director,	1 ☐ Yes 2 No	dospitel: 1 Inpatient 2	ER/Outpetient 3	DOA O	ther: 4 Nursing Ho	me 5 Resid	lence 6 Oth	er (Specify)
Affer fune	27. Menner of Deeth  Neturel 5 Pending  Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo	ury at ork? ☐ Yes 2 ☐ No	28d. Describe h	ow injury occur	red
DIVISION of Attending a strated ath. I Director: After d in by the fune Sertification	3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, ferm, street, fe	ctory, office		28f. Location (5 City or Tow		er or Rurel Route Number,
Division ( To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	29e. Certifier Check only 2 Hedical Exami	elcian: To the best of my kr ner: On the basis of examin and menner steted.						
To the Ho within 24 1 To the Fu Completel		de Mes		29c. Licen	ise pumber of	,	29d. Deta signe	d (Month, Day, Year)
5	30. Name and address of person who or			DILLE	TOLLOGS	her man	LOBIE	01007
Con	31. Dete filed (Month, Dey, Year)	M. D. 76 Ø1		RIVE	, TOWSON	, MARY	LHND.	21204
State Registrar	100	100 Depur	21 /9	Esoca.	Kal			

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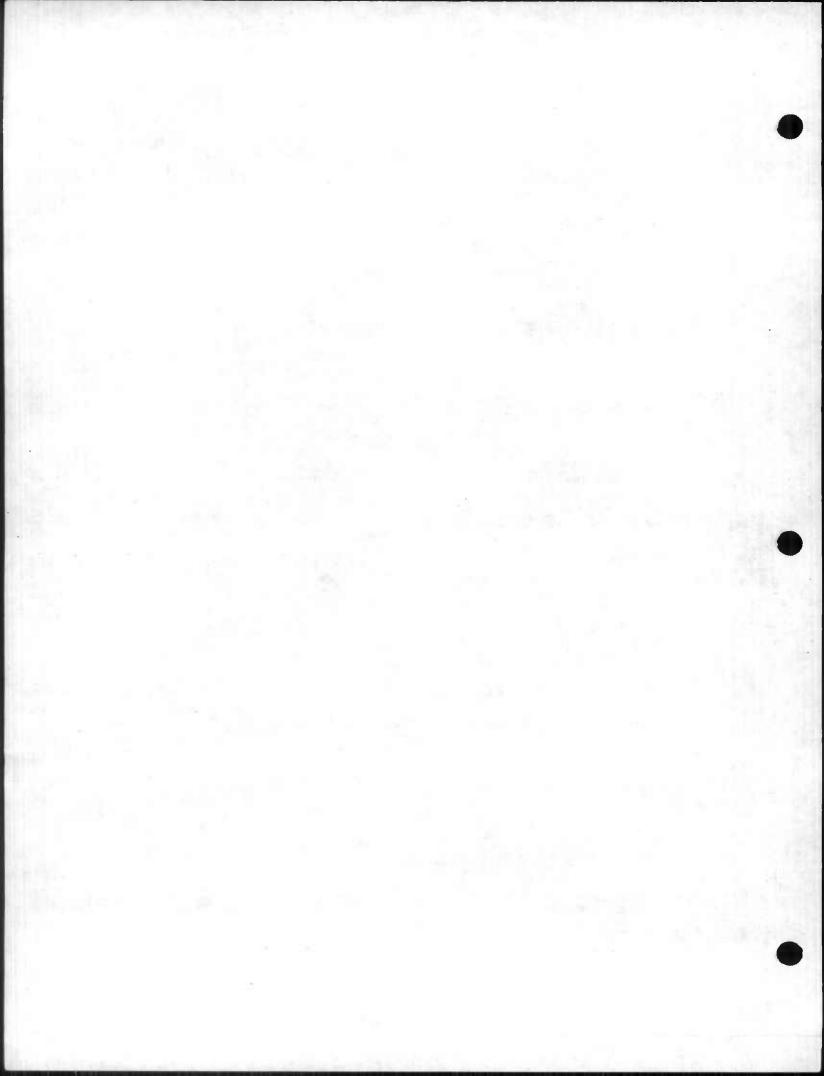
DHMH 16 Rev 6/95



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Physician /Medical	Anna C. Brauns	stein			11	25 200	In a A m				
Examiner	4e Facility Neme (If not Institution	, give street and number)			4b. City, Town, or L	ocation of Death	4c. County of De				
	Anne Arundel	Medical Cent	er	Annapol		Anne Arundel					
Funeral Director	5. Social Security Number		ge (In yrs. last bi	rthday) If Under 1 Yes Months Dev		8. Dete of Birt	th 9. E	Birthpleca (Stata or Foreign Country)			
	579-09-9943	1□M 200 F	78	Yrs.	110010 111111	8. Dete of Birth (Month, Dey, Year) Jan. 2, 1921 Washington,					
	Usual Residence of Decedent										
how the	10a. Stete 10b. County				10d. Inside City Limits						
Cto Me Me	MD Prince	e Georges		1 ☐ Yes 2♥No							
with the Merylery a or 28s-f show be notified a	10e. Streef and Number					10g. Citizen of Whet Country?					
23a		treet		207	737		USA				
fiter death vertical funeral	11. Meritel Stetus	12. Was Decedent Armed Forces?	12. Was Decedent Ever in U,S. Armed Forces?  13. Wes Deceder !! Yes, specify			pecify Yes or No	No- 14. Rece - American Indien, Bleck, White, etc.				
by	3  Widowed 4 □ Divorced			1□Yes ŽIXN			Specify: White				
15-003 n 72 hours "natural",	15. Deceden	's Education	16a	. Decedent's Usuel Occ	upation	1-2-	16b. Kind of Busines	ss/Industry			
21215-0 ed within 72 ho vgjene. er than "natum 4, tra Medical	(Specify only highest Elementary/Secondery (0-12)	1	Collega (1-4or 5+)		ne during most of work red)	king .					
d 212.	12	Somga (1 401		ffice Manag	ger		Insurance				
be filed the filed dother event, Be Co		Last)			18. Mother's Nam	na (First, Middla,	, Maiden Sumame)				
Aentel Aentel Red o Bo		i			Madell	e Grant					
Maryland 12 should be 1 12 should be 1 11 a marked of traumatic eva	19e. Informent's Neme/Raletions	hip (Type, Print)	198	. Meiling Address (Stre	et end Number or Ru	ral Route Numbe	ar, City or Town, State	a, Zip Code)			
	Richard Brauns	tein (Son)	6	741 N. Camp	bell, Chi	cago, II	L 60645				
or Haal	20e. Method of Disposition		20b. Piece o	f Disposition (Name of ry, crematory or other p	(aca)	Dete	20c. Location - City	or Town, Stete			
0 2 = 1	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donefion 5 ☐ Other (Si			Hill Cemet		11/29	Suitland,	MD			
Baltimo permit. Pag Department important: It any Injury o	21. Signeture of Funeral Sarvice	**		22. Neme end Add		2000	,				
Balt pemit. Departminporta any inju	1	Q7.	11	Hardest	y Funeral						
	23a. Pert1. Enfer the disease, or shock, or heert feilura. List	F. Net	ta death Do				polis, MD	21401 Approximata			
/Medical Examiner walled	Immediate Cause (Final disease or condition resulting in death)  a. Cheonic DBSTRUCTIVE Pulmonally DISEASE > 5 year Dua to (or as a consequence of):  Due to (or es e consequence of):										
P.O. BOX 68760, not the deeth certificate be associted by the attending physician and letached for use as the burial-transit Physician/Medical Examir	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest  Due to (or es e consequence of):  Due to (or es e consequence of):										
Class of the Class	Death Other Levins					23b. Did tobacco use contribute to the cause of death?					
dS, P.O. I	Part II. Other significant condition	ns contributing to death b	out not rasulting i	n the underlying cause	gven in Pen I.						
	CONGESTIVE	HEART	onic	1 1 2 Yes 2 No 3 Probably 4 Unknown							
requestion show		LURE, CE	24a. Wes	24a. Wes en autopsy performed?  24b. Wera autopsy findings available prior to completion of cause of death?							
VITAI REI					10	Yas 2 No	1 Yes 2 No				
otor. p	25. Was case rafarred to medical		26. Place of Death (Check only ona)								
Of VIta Physician: this certific ral director.	examiner?	Hospitel:									
Attending Physic Attending Physic Attention of the funeral distriction: To illication: To		28a. Dete of Inju (Month, Da	iry 28b.	Time of 28c. In			28d. Describe how Injury occurred				
Division of To the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After the completaly filled in by the funeral Medical Certification:	3 Sulcide 6 Could r 4 Homlcida datam	ined   286. Pieca of inj	jury - At home, 1e c. (Specity)	erm, street, fectory, office	28f. Location (Street and Number or Rural Route Number, City or Town, Stela)						
ne Hospitu n 24 hours ne Funera pletaly fille											
Vithin To the	29b. Signature and title of certifier	1		29c. Lice	nsa number		29d. Data signad (Month, Day, Year)				
- > - 0	> <10	1/1/1		02	8687	7 11/25/00					
15	20 Name and editions of T	The completed	looth /Item 02-1								
	30. Neme end address of person			(Type, Print) 139 0410	solomo	n's islo	nd Rd A	2140/			
State Registrar	31. Dalaried (Month, Day, Year)	32. Registr	rar's Signature	Son V							

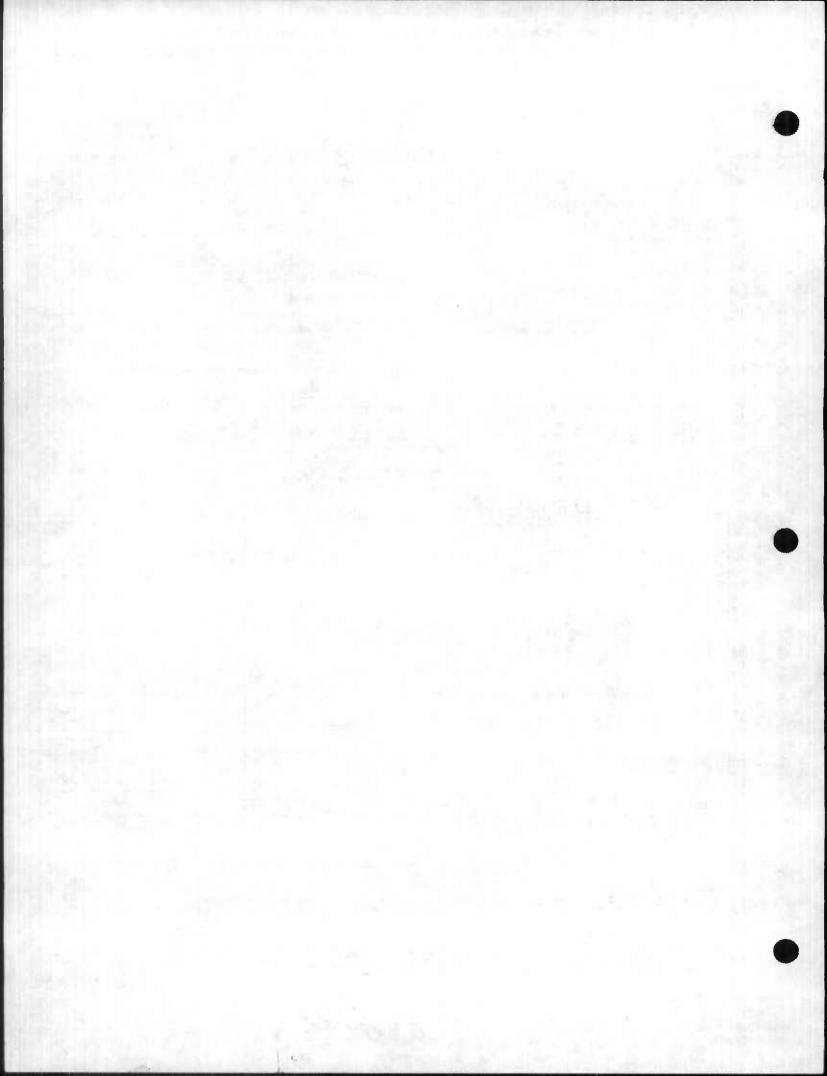
DHMH 16 Rev 6/95



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Physician /Medical		Decedent's Name (First, Middle, Last)							2. Dete of Deetl Month			Эу	Yeer			
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Funeral Director	-10	Scciel Security N		6. Sex	м 2 <b>XX</b> F	Age (In yrs.	. lest birthdey) Yrs.	If Unde Months	or 1 Year Deys	If Under 24 Hrs Hours Min		irth Bey, Year,	910	9. Birthple Country Virg	ce (Stete or	Foreig
	Us	suel Residence o	f Decedent		30						10 41 2	, _	320	* 9	21120	
* u	10	10e. Stete 10b. County 10c. City, Town or Location												100	d. Inside Cit	y Limit
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		1024 For	est Hi	111 7	Avenue					403		UŞ	SA			
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natural", odical Ex-		15. Decedent's Education 16e. Decedent's Usuel						uel Occup	pation		16b. H	Kind of Bu	siness/Indu	istry		
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Health em 27 i other tra	0	Charlott	e Pant	:alec	Daug	hter)	2709	Cori	iande	er Place,	Edgewa	ter,	MD	21037		
T E E	20	a. Method of Dis					Plece of Dispos cemetery, cren	sition (Ne	ome of	ce)	Dete	20c. L	ocation -	City or Tow	m, Stata	
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Depertment Important: if any injury or pace.	21	1. Signeture of Fu	ineral Service	e License	3 1	/	22	Harc	end Addre	ss of Fecility Funeral	Home.	P.A.				
0 = 4 4	Hardesty Funeral Home, P.A.															
	12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approxime											noli	c M	D 214	01	
	20	3a. Pert1. Enter t	he diseese, o	or compli	cations that ca	used the dea	th. Do not ente	12 F					s, M		Approximete	ŀ
	20	3a. Pert1. Enter t shock, or hea	he diseese, o rt failure. Lis	or compli st only or	cations that ca	used the dea ch line.	ith. Do not ente	12 F					s, M			veen
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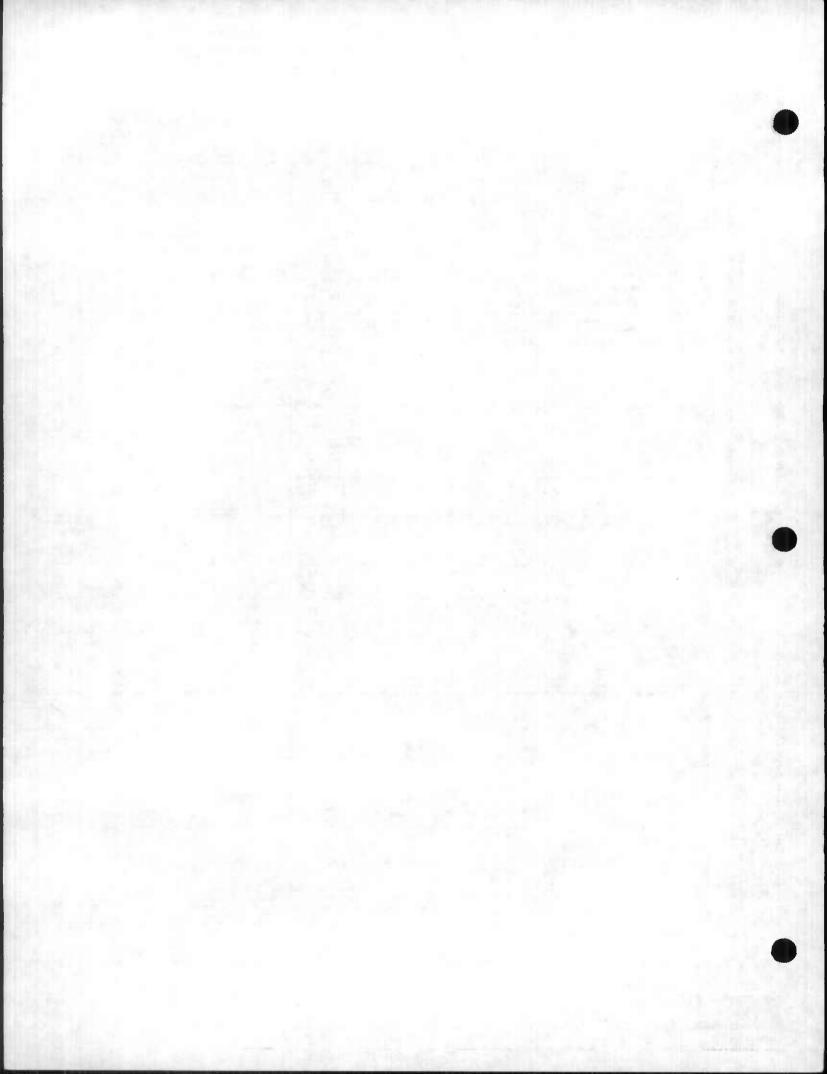
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State of Maryland / Department of Health and Mental Hygiene	3	12		
- 1111				

	1. Decedent's Neme (First, M	iddle, Last)				2. Date of Death Month		3. Time of Deal	
hysician /Medical	Milton Dougla	s Ballantine				November		8:20pm	
Examiner	4a Facility Name (If not institu	ution, give street and number	r)		4b. City, Town, or L	ocation of Death	4c. County of	Death	
	Heritage Nursing	Home			N/A		Baltimon	6	
ineral	5. Social Security Number		Age (In yrs. last birthd	ay) If Under 1 Yeer Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or For Country)	
rector	21.3 05 331.5	12 M 2□ F 83	Yrs	. Working Days	1,0013	September	14,1917	Baltimore City	
	Usual Residence of Decedent		10c. City. Town o	r Location				10d. Inside City Lir	
of a Po		N/A	Baltimore					1 ☐ Yes 2 ☐	
or 28a-1 a be notified Director	10e. Street and Number	IV A	DETCHINGE	10f. Zip Code		10	g. Citizen of Wh	at Country?	
D D	1144 5 1	2010 10		21206			USA		
r items 23e or 28e-f sho siner must be notified at Funeral Director	11. Merital Stefus	12. Wes Deceden	f Ever in U,S.	13. Was Decedent of I	Hispanic Origin? (Sp	pecify Yes or No-	14. Rece -	American Indien,	
五 五	1 Never Married 2 N	Armed Forces  Merried 1 ∑ Yes 2 ☐  If Yes, Give				Rican, etc.)		White, etc.	
Erami by F		ced Year or Dates	: WII	1 ☐ Yes 2 🕅 No	Specify:		Specify:	White	
t, the Medical Completed	15. Dece (Specify only hi	dent's Education ghest grade completed)	16a. De	ecedent's Usual Occu	pation during most of work	kina 1	6b. Kind of Busi	ness/Industry	
and de	Elementary/Secondary (0-1		- Iii	e. DO NOT use retire	nd)				
Co the	12	N/A_	Detec	tive				City Police De	
de se	17. Father's Neme (First, Mide					ne (First, Middle, M	raiden Sumame)		
metic e					Ada Irene				
4 5	19a. Informant's Name/Relati			lailing Address (Stree				ate, Zip Code)	
or other to	R Virginia Stroem	er (Sister)	4411	Parkmont Av	venue Baltin	ore, Maryl	and 21206	ity or Town, State	
2 b	1 Burial 2 Cremati	on 3 Removal from Stat	0	sposition (Name of crematory or other pla					
riant	4 Donation 5 Othe	***************************************	Dulaney V	Valley Mem. (	idns. Novemb	er 21,2000	Timoniur	n, Maryland	
my ir	21. Signature of Funeral Serv	ice Licensee	-	22. Name end Addre Lassahn Fur	ess of Fecility neral. Home I	inc			
	Leather	man Cho	rade	7401 Belair	Road Balti	more, Mary	land 21236	5	
	23a. Part1. Enter the disease shock, or heert failure.	, or complications that cabe List only one cause on each	of the death. Do not line.	enter the mode of dy	ing, such es cardiac	or respiratory erre	st,	Approximate Interval Between	
sician	26,75,711111			,				Onset end Deet	
edical miner	Immediate Cause (Final disease or condition	AI	LZHEI	MERS	DEM	ENTIF	1 .		
	resulting in death)		Due to (or as a cor						
in and fal-transit Examiner		b							
ohysician and the burial-transit dicai Examir	Sequentially list conditions, if env. leading to immediate		Due to (or as a con	sequenca oi):					
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>c</b>					-76-1		
- o d)	resulting in death) Last		Due to (or es a con	sequence of):					
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ed by the attending detached for use a detached for use a						L est Dida:		do do do do acceso de de	
y the ched	Pert II. Other significant con-			e underlying cause g	iven in Part I.			ibute to the cause of d	
detac detac		RHINIT	. 2 (			1 U Y	s 2□No 3	Probably 4 5 Uni	
signed I						24a. Was ar		24b. Were autopsy lindii	
should should leted						perform	ned?	eveilable prior to completion of caus of death?	
© (N □						4 🗆 Va	· orbio	1 Yes 2 No	
rector, pag		4:1				1 Ye		TLI TES ZERNO	
s certificate he director, page To Be Com	25. Was case referred to med examiner?	Hospital:	та оПерио	OI	ther:	th (Check only on		(Canada)	
r this contained in the second	27. Menner of Death	1 ☐ Inpa 28a. Date of In	jury 28b. Tim			ome 5 Reside			
to to	1 Natural 5 Per	nding (Month, E	Say Year) Inju		ork? ]Yes 2 □ No				
to the	3 ☐ Suicide 6 ☐ Co	uld not be	niury - At home, farm	, street, lactory, office				or Rural Route Number,	
al Director: After t ed in by the funera Certification:	4 Homicide	building,	etc. (Specify)			City or Town			
B C E	29a. Certifier 1 Certi	fying Physician: To the bes	t of my knowledge, d	eath occurred at the t	ime, date and placa	, and due to the ca	use(s) and man	ner as stated.	
()		cal Examiner: On the basis and manner:	of examinetion and/o						
Adio Polote	29b. Signature and title of cer	tifier			se number		d. Date signed	(Month, Day, Year)	
To the Funeral Director: After completely filled in by the fune Medical Certification	► K / Plannesung MeD. D17753 11-21								
To the Funeral Director: After the completely filled in by the funeral Medical Certification: 1			death (Item 23a) (Ty	pe, Print)				RE, MD 212	
complete  Medic	30. Name and address of pers	SOLI MUO COMPRETED CAUSE OF		- 7/10	A A	~ DA	1 - 110	00 1 0 00	
To the Fu complete	30. Name and address of periods	AARMASE	=NA, Me	D. 710	CHUKCH	Jo. 131	211110	14E, MW 212	
state State	1 6 -	PAMASE  Bar) 32. Regis	strar's Signature			55. JSA	2111/10	14E, MO 213	
in	K.S. DE	PAMASE  Bar) 32. Regis		6. Spor		JA. BA	2111/0	14E, MO 21S	



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State of Maryland / Department of Health and Mental Hygiene	U	3 /

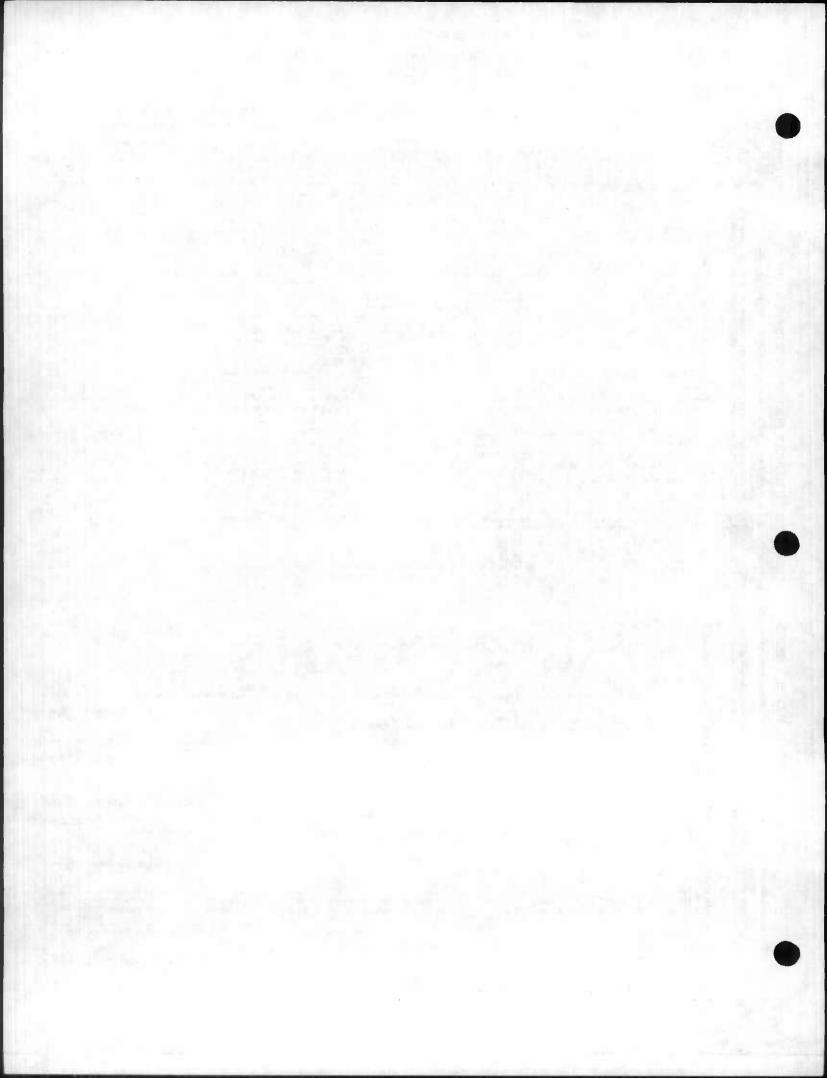
				Olato of Maryla		tificate of			g. No.						
	Dhomining	_	1. Decedent's Name (First, Middla, L.	ast)				2. Date of Death Month	Day	Yeer	3. Time of Death				
	Physician /Medical		Melvin Lewis	Biggs				Nov. 22	2, Day 200	0	1:25pm				
ز	Examine	-	4e Facility Neme (II not institution, gi				4b. City, Town, or L		4c. County						
L			Genesis Elder			M Hadar 1 Vaar	Dundal If Under 24 Hrs.		Balt						
	Funeral Director			Sex 7. Age (In yrs	Yrs.	If Under 1 Yeer Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV. 30	Yaar) ,1930	9. Birthpl Count WV.	ace (Stata or Foraign ry)				
	f show	1	10a. State 10b. County Md. Baltir		ty, Town or Lo		1			10	Od. finside City Limits				
	firer deeth with the Marylar ritema 23s or 28s-f show wher must be notified at Enemenal Director	2010	10e. Street and Number 2924 Yorkway			10f. Zip Code 21222		10	g. Citizen of W	het Count	ry?				
Maryland 21215-0020	or forms	2	11. Marital Status  1 □ Never Merried 2 ☒ Merried 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub	Hispanic Origin? (Sp en, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black	- America c, White, e	etc.				
15-0	ed within 72 ho ygiene. er than "natur ft, or Medical	200	15. Decedent's E (Specify only highast gi	ducation ada complated)	16a. Deced	dent's Usual Occup kind of work dona	pation during most of work d)	king	6b. Kind of Bu	siness/Ind	1 Tyes 2 No ntry?  can Indian, etc. te  dustry  otors  p Code)  own, State  iver				
121	within ene.		Elementary/Secondary (0-12)	College (1-4or 5+)		ter Mec			Genera	1 Mc	tors				
9	other than other than out, or M		YYS. 17. Father's Name (First, Middla, Las	1)	Has	ter Mec.		e (First, Middla, M							
lan	Table II	) I	John P. Biggs	5			Thelma	Julia	Wisen	an					
any	A DE E		19e. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Straat	and Number or Ru	ral Routa Number,	City or Town,	State, Zip	Code)				
	end 2 selth a 27 is		Priscilla Big				ay, Dunc	lalk Md.	2122	2					
Baltimore,	Peges 1 nent of He int: If item iry or oth		20a. Method of Disposition  1  Burial 2 □ Cremetion 3 [  4 □ Donation 5 □ Other (Special Contents)	Removel from State	cematary, crar	sition (Nama of matory or other ple Hill Ce	em . N	ov. 27,	Middl	City or Too	wn, State .Ver				
Balt	permit. Pege Department of Important: If any Injury or ance.		21 Signature of Funeral Service Lice	20	Co	Name and Addre	Funeral lers Poi	Home (	of Dun	dalk					
		+	23a. Perti. Enter the disease, or conshort, or heart failure. List only	nplications that caused the dee	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory erre	st,		Approximate Intervel Between				
	Physician /Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. CEREBR Due to b. DEMEN		CUCAR quenca of):	Acrob	ENT		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Onset and Death				
Box 68760,	g physicis as the bu	8	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last												
	death d for		Part II. Other eignificant conditione	contributing to death but not re	sulting in the u	nderlying cause di	ven in Part I	23b. Did to	bacco uae con	tribute to	the cause of death?				
P.O.	requires that the death cent seen signed by the attending should be detached for use a		atti odio ogimodii odio			3 Prob									
of Vital Records,	been should	3000			A.		Wille.	24a. Was ar perform	n autopsy ned?	eva	ore autopsy tindings illable prior to impletion of cause death?				
A.	The lew ate has page 2	5						1 □ Ye	s 2 <b>X</b> No	1 🗆	Yes 20 No				
/ita	certificate rector, pag		25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on	a <i>)</i>						
of V	2 00	2	1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatient 2 ☐		IT 3LI DOA	43	ome 5 Reside			)				
Division	p 000	1000	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		28b. Time of Injury	Wo	ry at irk? ] Yes 2 □ No	28d. Describe ho							
DIVI	is after death. Is after death. In Director: After de in by the fu		3 Suicide 6 Could not 4 Homicide determined		nome, farm, str ify)	eet, fectory, office		28f. Location (Str City or Town	reet and Number, Stata)	er or Rura	I Route Number,				
	Hospit 24 hour Euner etely fill		29e, Certifier (Check only one)  12 Certifying P 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death ation end/or in	n occurred at the ti vestigation, in my	me, date and placa opinion, death occur	, and due to the ca rred at the time, da	use(s) end me ate and placa, a	nner es st and due to	eted. the ceuse(s)				
	ST S		29b. Signature and title of cartifier			29c. Licen	se number	29	9d. Date signed	(Month,	Day, Year)				
P	1/1/		Saindy R	Sult "	75	D27	188		11/271	80					
	SIV		30. Name and address of person who are Kiles	completed cause of death (Ite	m 23a) (Type,	Print) Vlace P	atti m	oe MD	212	22					
ì	State Registrar		31. Date filed (Month, Day, Year)  NOV 2	32. Registrar's Sign	ature	B. 16	62 May 1								



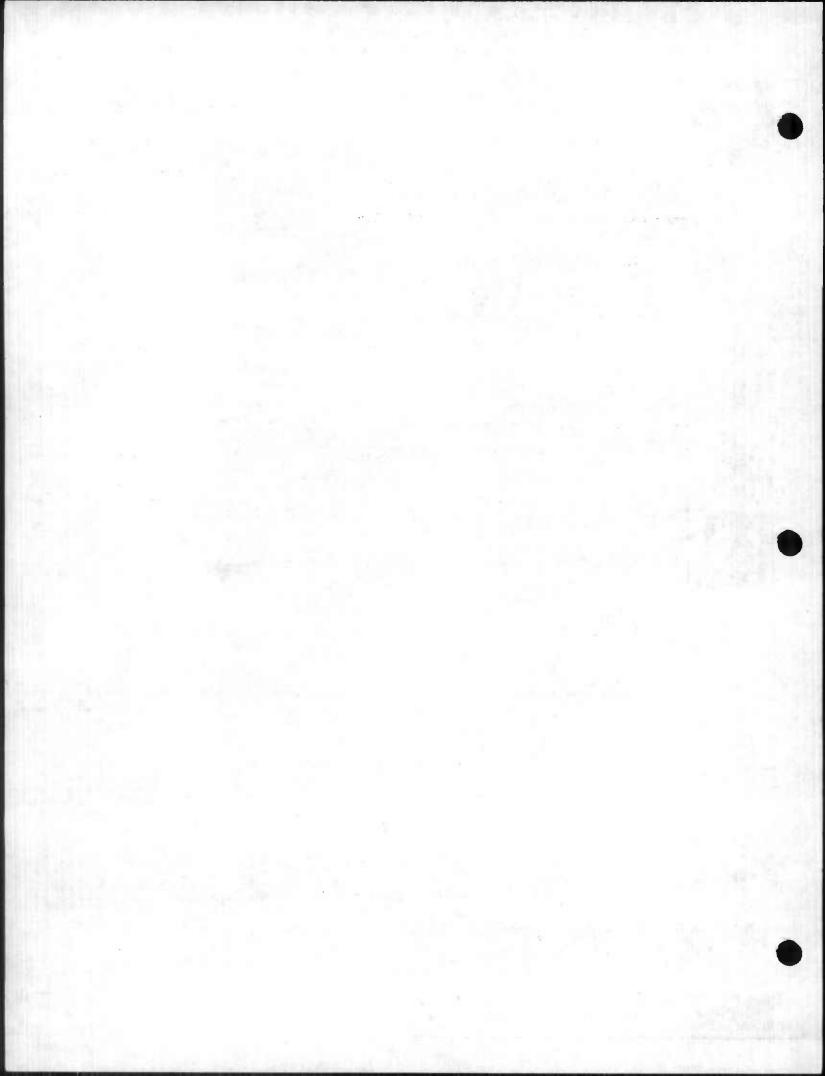
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State of Maryland / Department of Health and Mental Hygiene 37219

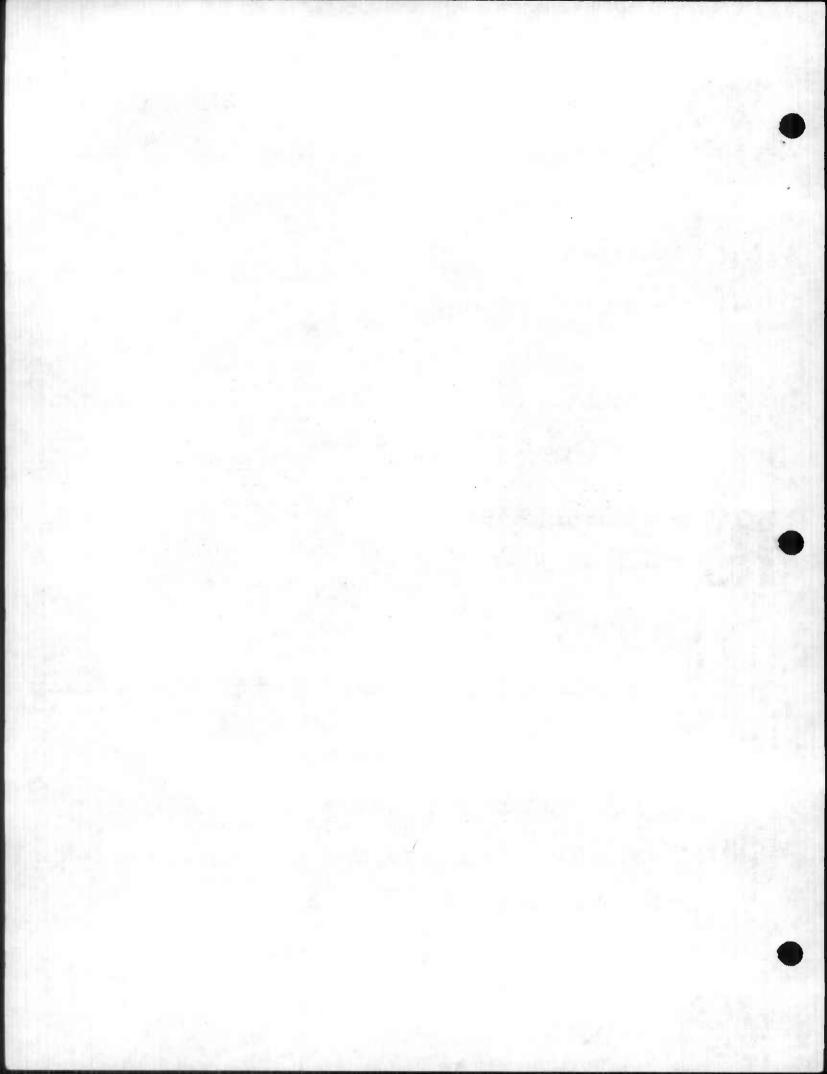
amend item 4	c per md G789 11/27/00 yf Certificate of Death	Reg	. No.	
Physician /Medical	1. Decedent's Nema (First, Middle, Last)  DOSEPH C. BARNES	2. Deta of Death Month	Day 17, 200	3. Time of Deeth
Examiner Funeral Director	46. Facility Name (I not institution, give street end number)  46. S. Town, or Los  5. Sociel Security Number  6. Sex  7. Age (In vrs. last birthday)  Vrs.  Wonth Deys Hours Min.	8. Date of Birth Month, Dey, Y	4c. County of Death  A S A  9. Birthy  21921 VIR	N/A placa (State or Foreign
Manyland a-f show find at	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  ALL MORE			Od. Inside City Limits
Unfor death with the Maryland referre 23a or 28a-f show rither must be notified at Funeral Director	10e. Street and Number  10f. Zip Code	Citizen of Whet Could  14. Flaca - Americ Black, White,	can Indian,	
n 72 hours no 72 hours of netural, of netural, of netural by	1 Nevar Marriad 2 Married 1 Yas 2 No If Yes, Give Year or Datas: WW II 1 Yes 2 No Specify:  15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12) College (1-4or 5+)	ing 16	b. Kind of Business/in	dustry
ire, Maryland 21215-0 s 1 and 2 should be filed within 72 ho I Health and Mental hygiene. Item 27 is marked other than "naturn other treumatic event, in Medical To Be Completed	MINISTER	e (First, Middle, Ma	ELIVER iden Sumama)	Ance
e, Marylan Tend 2 should be Health and Mental om 27 io marked o ther treumatic eve	19e. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street end Number or Run  19c. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street end Number or Run  19c. Meiling Address (Street end Number or Run  20c. Method of Disposition  20b. Pleca of Disposition (Name of	AUE. A	City or Town, State, Zing A 1 to Mr. C. Location - City or To	d 21215
Baltimore, Maryland 212 permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, fre. Any files of the comments of the comp	1 ID Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Offer (Specify)  21. Sign for a Funaral Sarvice Licensea  22. Name and Address of Fecility	Jones,	arto, M.	t pa
Physician /Medical Examiner	23a. Pert1. Enter the disease, or complications the causad tha death. Do not enter the mode of dying, such as cardiac of shock, or heart feiture. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		1.	Approximete Intervel Between Onset and Death
or 68760, certificate be executed ding physician and se as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last  b.  Due to (or es a consequence of):  c.  Due to (or es e consequenca of):			
Division of Vital Records, P.O. Box (or Attending Physician: The law requires that the death certificate death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a settification: To Be Completed by Physician/Mistrication: To Be Completed by Physician/Mistrication and Physician Mistrication and Physician Atlanta Mistrication and Physician Atlanta Mistricat	Parl II. Other significant conditions confributing to deeth but not resulting in the underlying cause given in Pert I.		acco use contribute to	o the cause of death?
Records, P.O.  s law requires that the de has been signed by the pe 2 should be detached mpleted by Physic	9	24a. Was an performe	42	fere autopsy findings vailable prior to emplation of causa death?
Vital Ricellan: The I certificate he irector, page	examiner?	1 ☐ Yes	STELLA MAI	Yes 2 No
Division of Vital Records, or Attending Physician: The law requires that of ceath.  Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by entification: To Be Completed by	27. Menner of Deeth 1 Netural 5 Pending (Month, Dey Year) 2 Accident investigation 3 Suicide 6 Could not be	me 5 ☐ Residen  28d. Describe how  28f. Location (Stre		
Division of To the Hospital or Attending P within 42 hours after death. To the Funeral Director: After completely filled in by the tuneral Medical Certification:	building, etc. (Specify)  29e. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	City or Town,	Stete)	stated.
To the within 2 To the comple	29b. Signeture end title of certifier  D 4085	4 No	UEMBER	20. 2000
State	30. Name and address of person who completed cause of daeth (Item 23e) (Type, Print)  DAVID R'SEBER9 30/ SFPAU/  31. Deta filed (Month, Dey, Year) 32. Registrar's Signeture	P/ BA	Himory	= MD2120
Registrar	NOV 2 7 2000 Seneral & Spaces			



			n ivialylai		tificate o		d Mental Hy	Reg. No.		<b>~ (.</b> 0
Physician /Medical	Decedent's Name (First, Middle,     Marie D	Last) . Blair					2. Date of D Month Novemi	Day	Yaar 2000	Time of Death  5:55pm
Examiner	4a Facility Nama (If not institution,	giva street and nu	, or Location of Dea	th 4c. County	of Death					
	Greater Balti	on								
Funeral Director	5. Social Security Number 215-07-6065	5. Sex 1 □ M 2 □ F	7. Age (In yrs. I		If Under 1 Yas Months Day		Min. (Month, D	rth ey, <i>Year)</i> 5-1910	Country)	(State or Foreign
9	Usual Residence of Decedent									
The Maryland 28a-1 show solified at ector	10a. Stata 10b. County		10c. Ci	ty, Town or Lo						inside City Limits
oto Mar M	Maryland Baltim	ore		Timon						1 ☐ Yes ZX No
or 28s-f a be notified Directo	10e. Street and Number				10f. Zip Code	Ŀ		10g. Citizen of V	Vhat Country?	
ral 123	2136 Pine	Valley			210				S. A.	
natural, or tems 23s or 28s-f show dical Examiner must be notified at sted by Funeral Director	11. Marital Status  1 Never Married 2 Marrie	Armed Fo d 1 ☐ Yes If Yas, Gi	2 No	if	Vas Decedent of Yes, specify Ci I□Yas 2□ N	uban, Mexican, P	? (Specify Yes or N Puarto Ricen, etc.)	Blac	e - American I k, White, etc. White	ndian,
ratural, or to dical Examinated by Fu	3 Widowed 4 □ Divorced	Year or D	Dates:		21					
nd within 72 ho ygions. we then 'natural, to the Medical.	15. Decedent's (Specify only highest			(Give	lent's Usual Occ kind of work dor	a during most of	working	16b. Kind of Bu	isiness/Indust	ry
SES DE	Elemantery/Secondary (0-12)	College (	1-4or 5+)		00 NOT use reti cretary	rea)		Docto	r's Of	fice
C Hard	17. Fathar's Nama (First, Middla, L	a ctl			7 - 0 - 0 - 1	18 Mother's	Name (First, Middle	Maiden Sumer	10)	
Asental H Hand off Hic even To Be	Augustine					Mar		Rosney	10/	
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N and	19a. Informant's Name/Reletionsh		10				or Rural Route Numi			
tastit m 27 ther to	Mr. Stephen A.  20a. Method of Disposition	Lochar	-		sition (Neme of	ilisn R	un Circle	20c. Location -		
rages riteriority any or of	1 Burial 2 Cremation	B □Ramoval from		cemetery, cren	netary or other p			7000		
- 左左三	4 Donetion 5 □Other (Sp.		Du				ds. 11-27	-00 Timo	nium,	Maryland
O Depart	21. Signature of Funeral Sarvice L	censee S. B.	ools 2	I		neral Home, Inc. Towson, Md. 21204				
	23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that	ceused the dea	th. Do not ente	er the moda of d	ying, such as car	rdiac or raspiratory	arrest,	Ap	proximate erval Between
Aysician // Medical Examiner    Gloss Examiner	Immediate Causa (Final disaasa or condition resulting in deeth)  Sequentially list conditions, if any, laading to immediate	a	PNE	RATO or as a consequence or as a consequence	uence of):	FAILU	RE			
Ex Cal	if any, laading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury									
	that initiated avents rasulting in death) Last	c	Due to (d	or as a consequ	uence of):					
death certific e attending p ed for use as sician/Mex										
A do A	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the ur	nderlying ceuse	given in Part I.		tobacco use co Yes 2□ No		e cause of death? ly 4 Unknown
igned be det								,		, ,
should								s an autopsy formed?	availal	eutopsy findings ble prior to etion of cause th?
hes ge 2							45	ver alde		es 2 No
	Of Manager of and to an disal							Yes 2000	1011	98 ZLJ NO
Physician: The Line of the Company o	25. Was cese referred to medical axaminer?	Hospitel:				Wher:	Deeth (Check only			
this cal direction.	1 Yes 2 No	28a. Date		28b. Time of	I 3LI DOA	4 LI NUISI	ng Home 5 ☐ Res	how injury occur		
To the first	1 Triatural 5 Pending 2 Accident invastige 3 Suicide 6 Could no	(Mor	nth, Dey Year)	Injury	V	☐ Yas 2 ☐ No		(Street and Numl		outo Mumber
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within 24 hours To the Funeral Completely filled Medical Co	29a. Certifier (Check only one) 1 Certifying 2 Medical E	karniner: On the b	best of my knowasis of exa <i>m</i> ino ener stated.	owledge, death etion and/or inv	occurred at the restigation, in m	time, dete end p y opinion, death	plece, and due to the occurred at the time	e cause(s) and me o, dete end plece,	and due to the	d. e cause(s)
Me dang	29b. Signature and title of conifier			I For	29c. Lice	ense nu <i>m</i> ber		29d. Date signe	d (Month, Day	r, Year)
	1	2-1			O	+456		11/14	100	
MILL	30. Name and address of person w	ho completed cau	se of death (Ite	m 23a) (Type			U	1101	CHEBN	i 15
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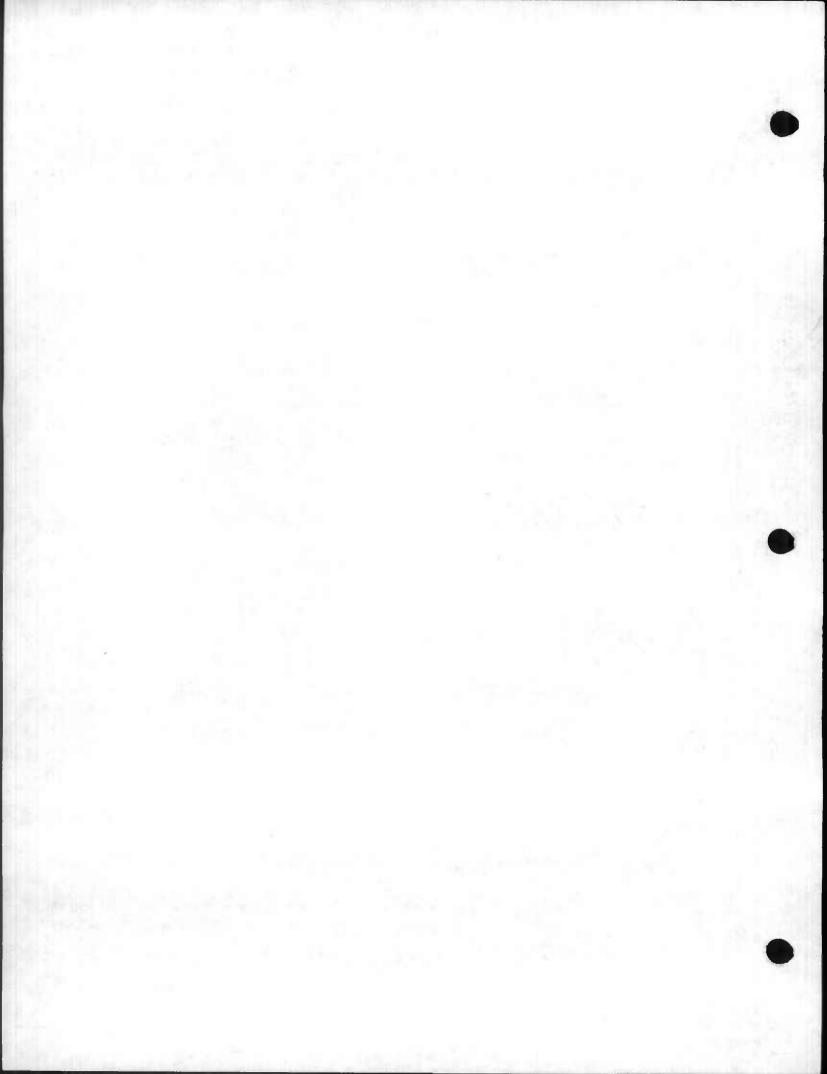


	1. Decedent's Neme (First, A	fiddle, Last)	0.00	47.5				2. Date of De		V	3. Tima of Death
nysician Medical	Edith M.	Brocato	)					Novembe	r 18, 2	2000 Year	7:00 pm
xaminer	4e Facility Neme (If not institution Good Samaritan			er)	4b. City, Town, o	r Location of Deat	h 4c. Co	ounty of Deat	h		
eral ctor	5. Social Security Number 213-10-5032 Usuel Rasidence of Deceder	6. Sex	Sex 1 M 2 X F 7. Aga (In yrs. last birthday) If Unc. Month				If Under 24 H Hours Mi		th		hplace (State or Foreign buntry)
	10a. Stele 10b. Co			10c. City, To	own or Location						10d. Insida City Limits
Director	MD N	I/A		E	laltimore						1X Yas 2 No
0	10e. Street and Number 4303 Cook Aven	iue			100	7. Zip Code 21206			U.S.A		
by Funeral	11. Marital Status  1 Never Married 2  3 XWidowed 4 Divo	Married	Armed Forces? If Yes, sp			ecedent of H specify Cubo as 2 No	dispenic Origin? en, Mexican, Put Specify:	(Specify Yes or Ne erto Rican, etc.)		. Rece - Ama Black, White pecify: Whi	e, etc.
Completed	15. Dece (Specify only hi	15. Decedent's Education (Specify only highest grade completed			6e. Decedent's (Give kind o	Usuel Occup	pation during most of w	orking	16b. Kind	of Business/	Industry
ошо	Elementary/Secondery (0-	12)	College (1-4d	or 5+)	Homemak		0)		OW	n home	
8	17. Fathar's Nema (First, Mid	idle, Last)	Atkinson					ame (First, Middle	, Maiden Su	ımeme)	
Jo.	19e. Informent's Name/Relat	llonshin /Tv			9h Meiling Add	trass (Straat	Catherin	e H. Rural Route Numb	er City or 7	Town State 2	Zip Code)
	Russell C. Broo							MD 21206	.,,		,
	20e. Method of Disposition 1 ☒ Burlal 2 ☐ Cremet 4 ☐ Donalion 5 ☐ Othe		emovel from Ste	te ceme	of Disposition etery, cremetory	or other plea		Dete 11/22/00		more, M	
9000	21. Signeture of Funeral Sen	vice License	William	G. Dau				onard J. R timore, MD			me, Inc.
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** 10:31 AM SAM BIENENFELD November 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not institution, give street and number) Examiner N/A Baltimore City Singu Hospital of Baltimore 8. Date of Birth (Month, Day, Year) SEP 26, 1927 If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 □ F 086-24-3874 73 Yrs. N.Y. Director Usual Rasidanca of Decedent 10a Stata 10b. Count 10c. City, Town or Location 10d. Inside City Limita 1 X Yas 2 No MD N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? or itsms 23a or the Medical Examiner must be 6302 GREEN MEADOW PARKWAY 21209 U.S.A. Funeral 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Giva Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14 Race - American Indian Black, Whita, atc. filed within 72 hours after Hygiene. 1 Never Merried 2 Married Dienenteld, Samaitimore, Maryland 21215-0020 1 Yas 2 No Specify: WHITE Specify ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working iifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) PLUMBER PLUMBING 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Meiden Sumema) 98 should be is marked **JOSEPH** BIENENFELD RACHEL SOVA 2 use 1 and 2 sho quartered of Health and As important; if I fem 27 is m any injury or other once. 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6302 GREEN MEADOW PARKWAY - BALTIMORE, MD 21209 ALICE BIENENFELD / WIFE 20b. Place of Disposition (Nama of camatary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 X Burial 2 Cramation 3 Removel from Stata SHOMREI EMUNAH CEMETERY 11/22/00 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Nama and Addrass of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 tions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Intarval Batween Onsat and Deeth Physician Immediete Ceuse (Final disaase or condition rasulting in daath) /Medical Preumonia 2 days **Examiner** Dua to (or as a consequence of): Examiner signed by the attending physician and I be detached for use as the burial-transit Sequentially list conditions, it any, laeding to immadiata cause. Entar Undarlying Cause (Disaase or injury Dua to (or as a consequenca of): certificate be exec Box 68760 Physician/Medical that initiated evants rasulting in death) Last Dua to (or as e consequança of) P.O. Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed page 2 should certificate has 2 1 No 1 Yas 2 No 1 ☐ Yas 25. Wes case rafarred to medical axaminer? Be 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 2 1 Inpatient 3 DOA 2 ER/Outpatient this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred Certification: After 1 Natural 5 Panding invastigation death. 1 Yas 2 No 2 Accident il or Attendi after death Director: A 3 Suicide 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) illed in by 4 | Homicida Hospital To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the ceusa(s) and menner as stated.

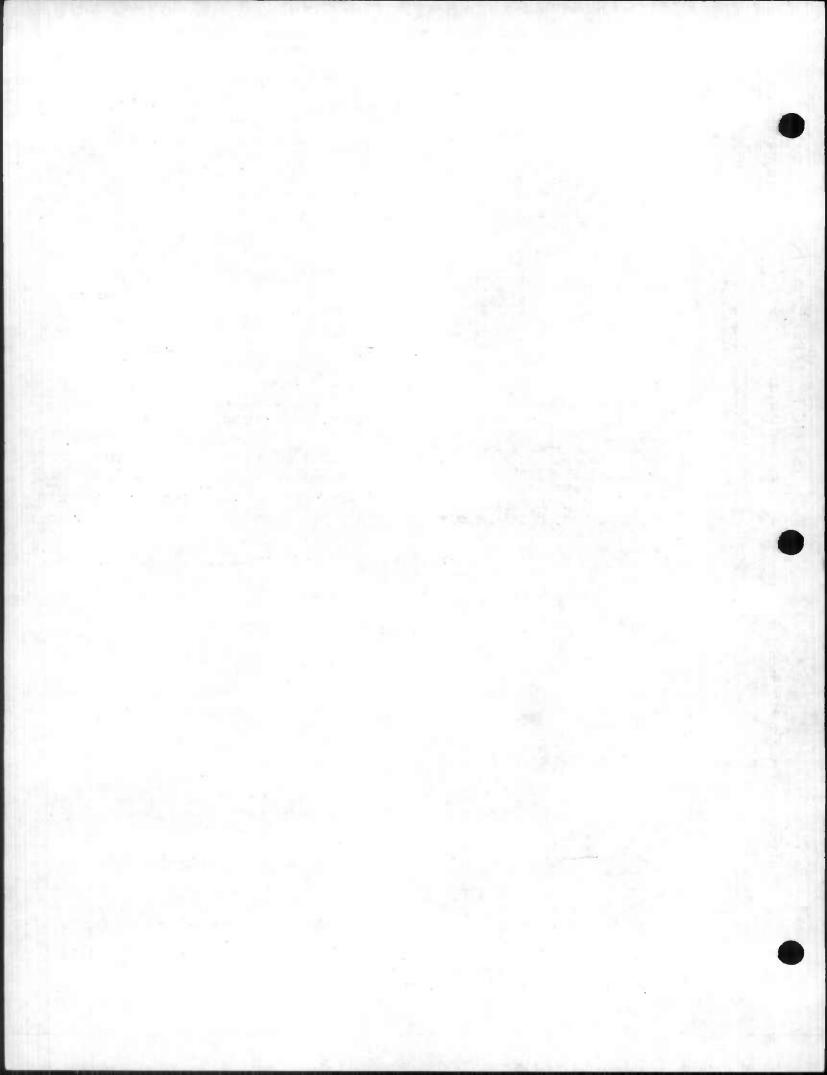
2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. edical 29a. Cartitier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signeture endititle of certifian 29c. License number 288 2000 Notember ww 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) Baltimore Valle Sinai 31. Dete filed (Month, Day, Year) 32. Registrar's Signetura Registrar NOV 2 7 2000



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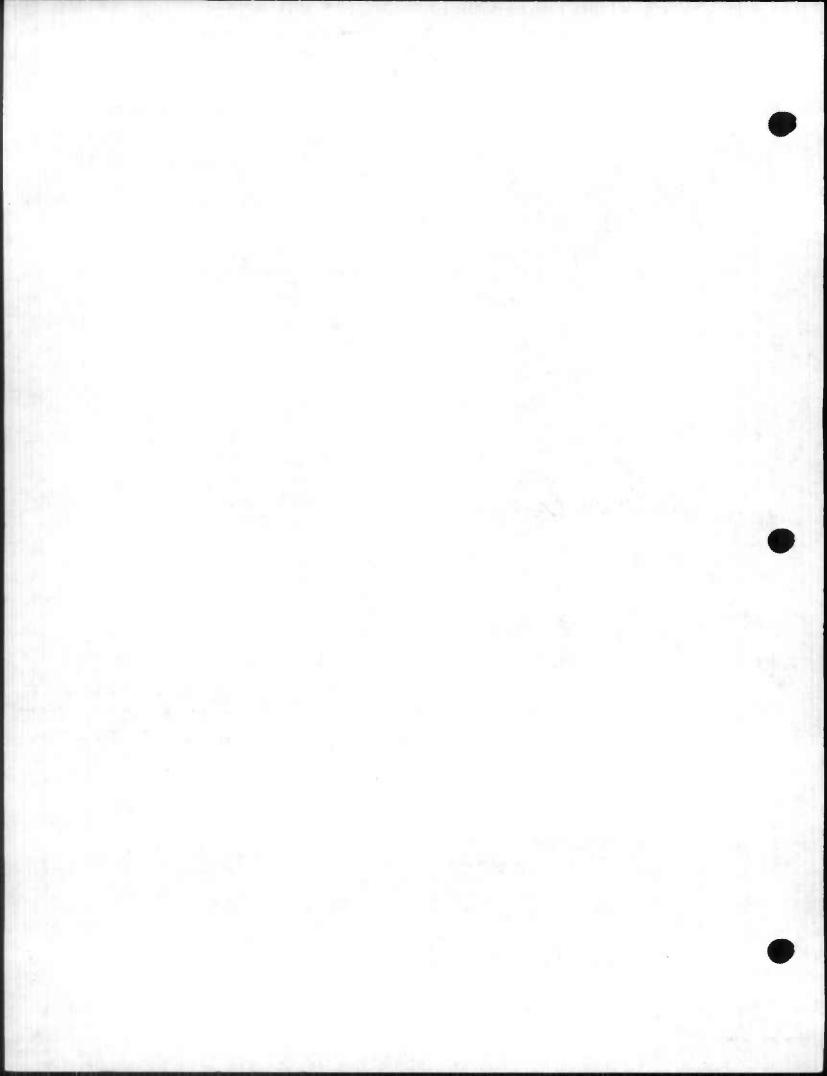
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etaly fillex	Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as significant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.													
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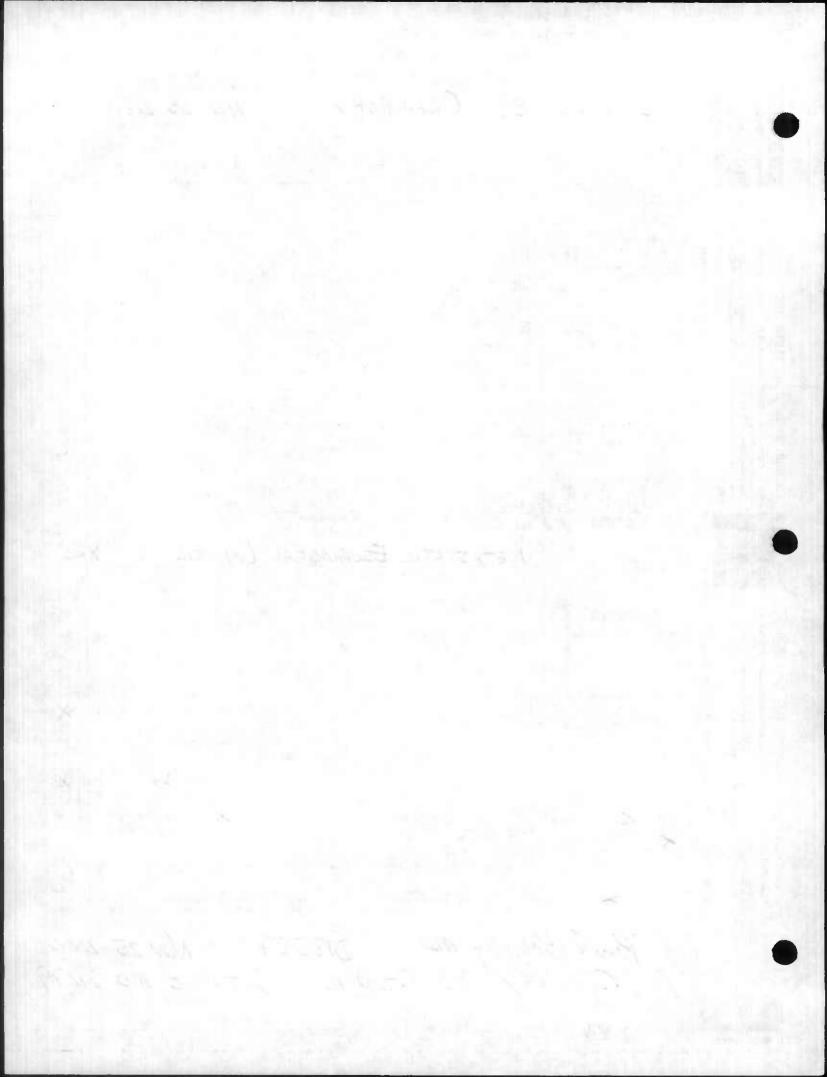


State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Data of Death 1. Decedent'a Nama (First, Middle, Last) 3. Tima of Death **Physician** RAWFORD DONALD 5AM 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street end number) 4c. County of Death Examiner 5506 Sycamore Ave. Arbutus Baltimore If Undar 24 Hrs. 6. Sex If Undar 1 Yaar 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ₹ M 2 □ F Months Days Hours Min 213-18-1394 80 Yrs. Director 01/29/1920 Maryland Usual Residence of Decedent the Maryland r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 ☑ No Director Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23s or the Medical Examiner must be a 5506 Sycamore Ave. 21227 United States permit. Peges 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itema 23a and Injury or other traumatic avant, the Medice Exprise man and other. Funeral 12. Was Dacedent Ever in U.S. Armed Forces? 1 ∑Yas 2 □ No 4 10 44 If Yes, Give Yaar or Datas: 2/5/46 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Nevar Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Machinist 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Thomas Gadd Crawford Anna Bertha Larsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) wife Mary R. Crawford 5506 Sycamore Ave. Arbutus, MD. 21227 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 Crametion 3 Removal from State 11/27/00 Burtonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1328 Sulphur Spring Rd Ambrose Funeral Home Inc. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** METASTATIC ESUPHAGEAL CANCER Immediate Cause (Finel disease or condition resulting in death) YRS /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): 68760 that initiated events resulting in death) Last Dua to (or as a consequence of): use as the Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 certificate hes 1 Ves 2 1 Yes 2 No Physician: 25. Was case referred to medical edicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Stresidence 6 Other (Specify) 1 Yes 2 No After this 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attanding 5 Pending investigation death. 1 Yes 2 No 2 Accident after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and the of outli 29c. License number of death (hero23a) (Type, Print) 30. Name and address 31. Data filed (Month, Dey, Year) 32. Registrar's Signatura State

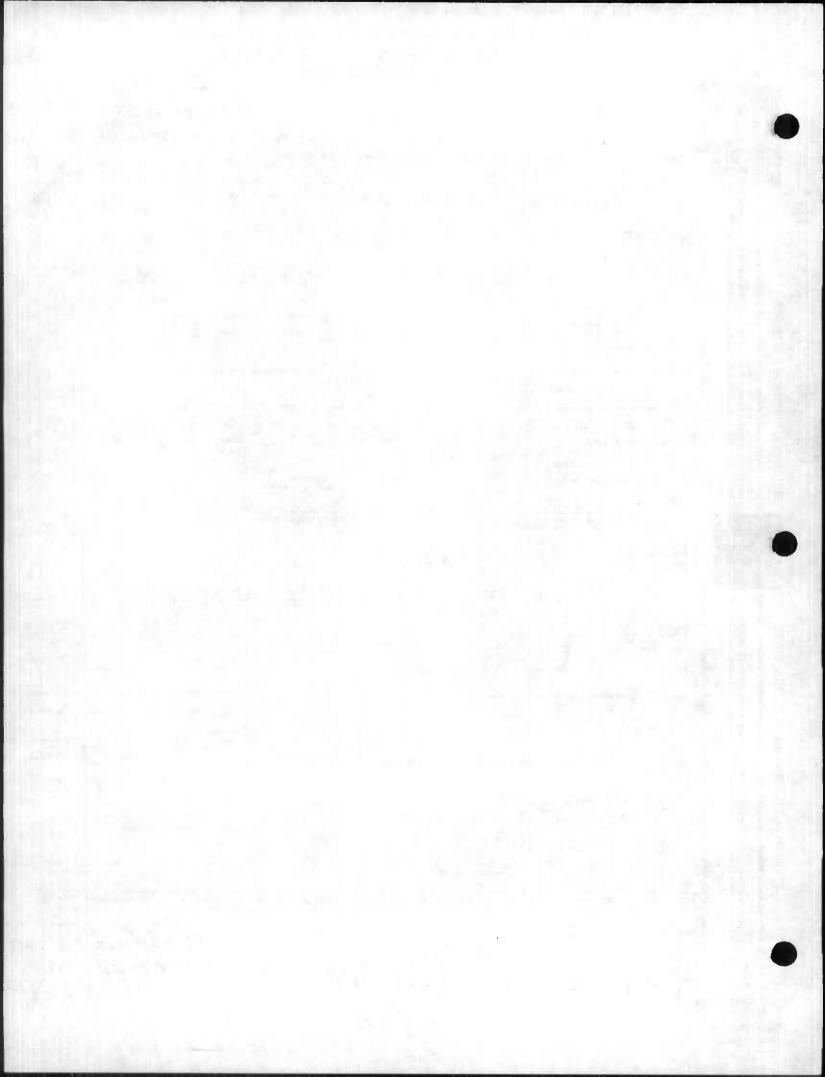
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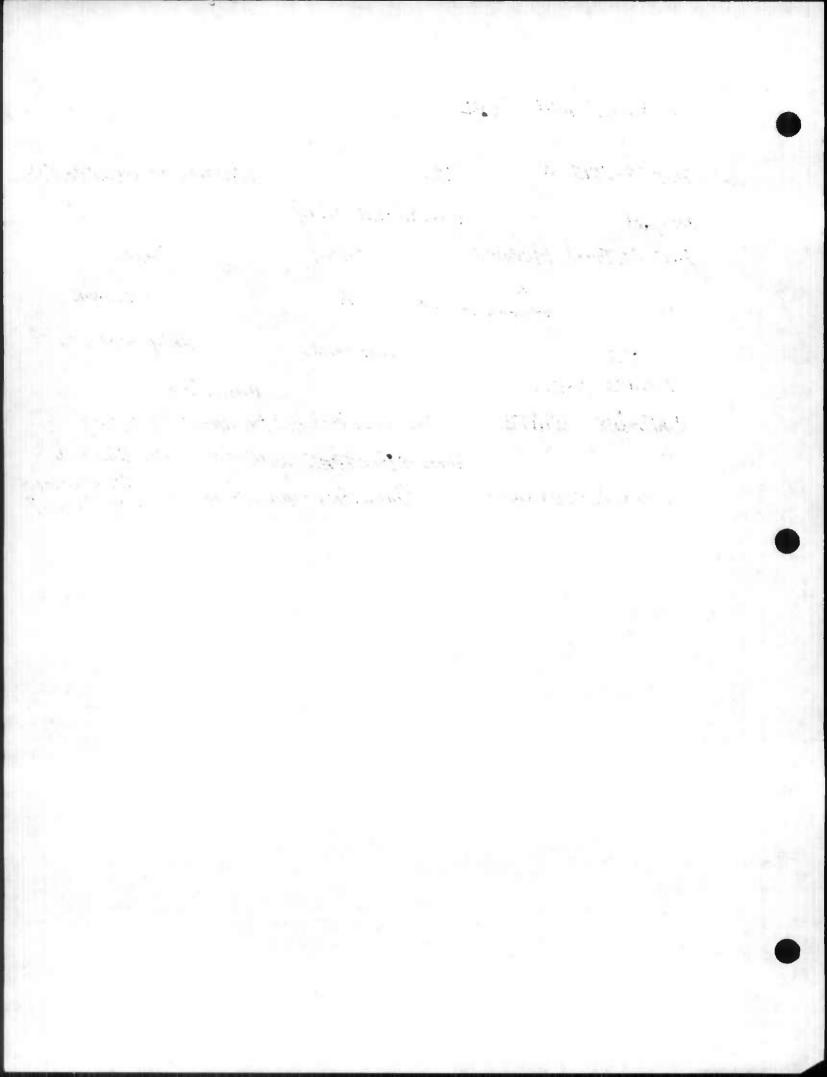
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Funeral Director		Sex 7. Age	(In yrs. last birt	rs. If Under		Under 24 Hrs. ours Min.	(Month, D	rth ey, Year) 7, 1967	Birthpiace (State or Forei Country)     Maryland		
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all hyders. d other than "natural", or items 23. went, the Medical Examiner must. Be Completed by Funeral		12. Wes Decedent Ex Armed Forces? 1 ☐ Yes 2 ( ) (No If Yes, Give Yeer or Detes:		13. Was Dece If Yes, spo	ecify Cuban, M	nlc Origin? (S lexican, Puerl pecify:	Specify Yes or N to Rican, etc.)		- American Indien, ;, White, etc. White		
	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	ication 16a. Decedent (Give kind life. DO			g most of wo	rking	16b. Kind of Bus	sinass/Industry		
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ked off to even to Be	Raymond A. Craw				10.		J. Ken		,		
permit. Pages 1 and 2 should Department of Health and Mi fittpoorlant; if Idem 27 is ment any injury or other treumed once.	19a. informent's Name/Ralationship	(Type, Print)	19b	Mailing Address	ss (Street and			Route Number, City or Town, State, Zip Code)			
	Betty J. Crawfor	d (Mother)				Myers		Dr., Martinsburg, WV 25401			
	20e. Method of Disposition  1 🔀 Buriel 2 □ Cremation 3 [  4 □ Donetion 5 □ Other (Speci		cemeter	Disposition (Ne y, crematory or Washi	other plece)	em.	11/25 2000	Aldephi	City or Town, State		
	21. Signature of Funeral Service Licensee  22. Name end Address of Facility Hardesty Funeral							P.A.	1 = 1 1 1 1 1 1		
11000000	23a. Pert1. Enter the disease, or con shock, or heart failure. List only	nplications that caused t	ne death. Do r					polis, Mi arrest,	D 21401 Approximete Intarval Batween		
attending physician and for use as the burial-trensit clary. Clary Medical Examiner	Cause (Disease or injury that initiated events	b. <b>2</b>	ue to (or as a	consequence of	ETI	ARD.	ATI	074			
for use		d									
igned by the se detached by Physic	Part II. Other significant conditions	Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I.						23b. Did tobacco use contribute to the cause of death  1 Yes 2 No 3 Probably 4 Minknow			
2 should			24a. W					s an autopsy formed?	24b. Wara autopsy tinding available prior to completion of cause of death?		
page Com		the first of the first of the first of						Yes 2 No	1 ☐ Yes 200No		
s certificate director, page To Be Co	25. Was cesa rafarred to medical examiner?  1 Yes 2 No	Hospital:	2 NEB/O	toationt 20 C	Other		ath (Check only		or (Snacity)		
After thi funeral funeral	27. Manner of Death  1 Natural 5 Panding  2 Accident investigation	28a. Data of Injury (Month, Day	1 Minpatient 2 ER/Outpatient 3 DOA				lome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred				
Director: In by the ertifical	3 Suicide 6 Could not lead to determine determined	200. Place of injur	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					(Street and Number own, Stete)	er or Rural Route Number,		
al Direct ed in by	S.A.	hysician: To the best of	xamination an	, daath occurre d/or investigation	d at the time, on, in my opinion	late and place on, death occi	e, and due to the urred at the time	a cause(s) and mai , data and place, a	nnar as stated. and dua to the cause(s)		
n 24 hours after d Ne Funeral Direct pietely filled in by a edical Certific	29a. Certifier (Check only one)  1 Certifying Plants one)  2 Medical Example 1	end manner state									
within 24 hours after deeth. To whe Funeral Director: After to completely filled in by the funeral Medical Certification:	(Check only 2 Medical Exa	end manner state	-m	D. 2	9c. License nu	664		29d. Date signed	(Month, Day, Year)		



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth .Physician KOBERT LEE November 19, 2000 12:54 P.M. /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner 2110 Westwood Avenue Baltimore 6. Sex 12 M 2□ F If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Yrs. SEPT 28 1908 DUPLIN CO. N.C. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov 1 Yes 2 No BATYMORE MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 2110 WESTWOOD UENUE Funeral filed within 72 hours after death Was Decedent Ever in U,S. Armed Forces? 1 AYes 2 No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 6 Maryland 21215-0020 1 ☐ Yes 2 No Specify: BLAGK þ 15. Decedent's Education
(Specify only highest grada completed) 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Hygiene. GREYHOUND BUS CO Elementary/Secondary (0-12) College (1-4or 5+) LABORER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Sumama) Pages 1 and 2 should be in ment of Heelth and Mentel and: If Item 27 is marked or JULIUS COEL MARTHA 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE Md. 2110 WESTWOOD Saltimore, 20e. Method of Disposition 20c. Location permit. Pages Department of H Important: If Ne any Injury or of phos. Burial 2 Cremation 3 Removal from State □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licansee E. Glover 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Arteriosclerotic Cardiovascular Disease Examiner Due to (or as e consequenca of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as e consequença of) P.O. 1 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown of Vital Records, Àq 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed Inspection 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1⊠ Yes 2 No Medicai Certification: To at scene this 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 ⊠Netural 5 Pending Investigation after death. 1 Yes 2 No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.A O.C.M.E. November 20, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey **Physician** 21, 2000 Frances Pauline Combs Nov. 11:20pm /Medical 4e Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1813 Maxwell Ave. Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 10 M 20 F Yrs. Director 214-24-8093 Nov. 5, 1927 Usual Residence of Decedent 10a, State 10c. City, Town or Location flied within 72 hours after death with the Marylan Hygiene.

Thysiene "natural", or frame 23e or 28e-f show ent, the Medical Examinar must be notified at 10b. County 10d. Inside City Limits Md. 1 ☐ Yes 2 No Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1813 Maxwell Ave. 21222 USA Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☑ No Specify: p 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 6 yrs. Housewife Home 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middla, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event page. 8 Major N. Terry Rosie F. Critzer 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Erhardt daughter 1908 August Ave. Dundalk Md. 21222 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Buriei 2 Cremetion 3 Ramoval from Stala
4 Donetion 5 Other (Specify) Nov. 25 Baltimore Oak Lawn Cem. 2000 ture of Furieral Service Lice 22. Neme and Address of Fecility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

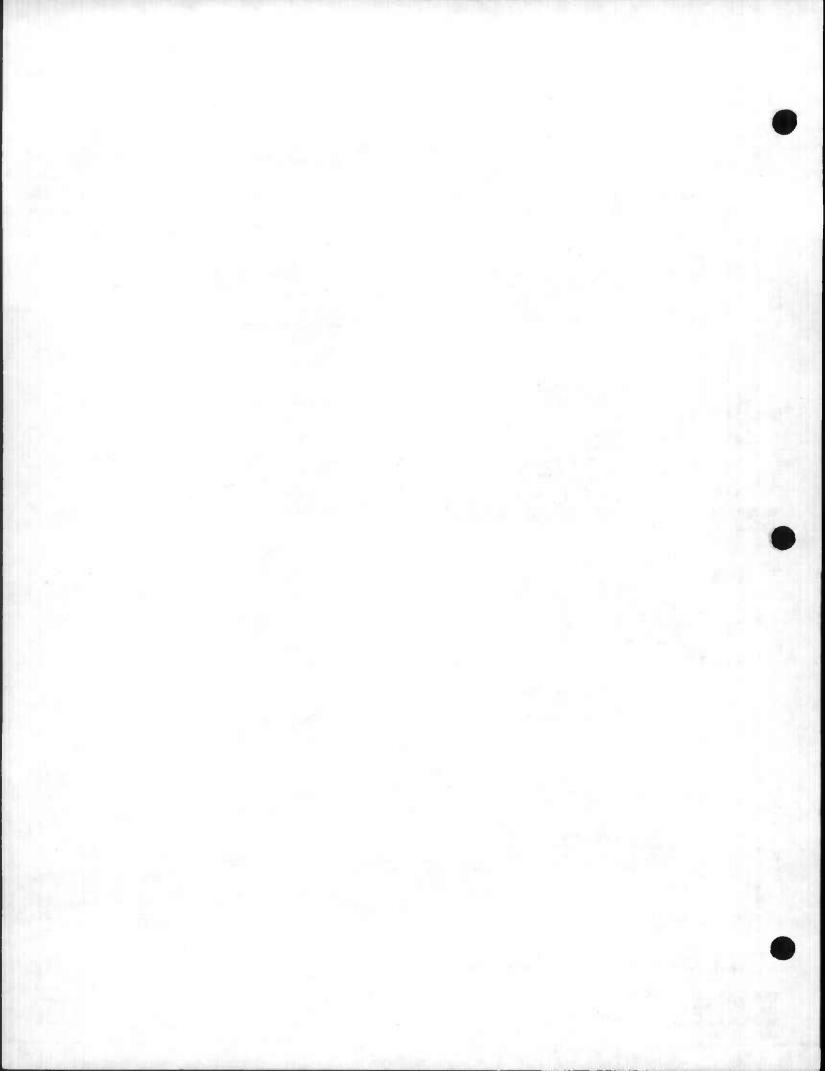
23a. Part Letter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Annual Point Rd. 201222 Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Peripheral Arterial Disease diseese or condition resulting in deeth) Examiner Physician/Medical Examiner attending physician and for usa as the bunial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thal initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Dua to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown þ Records, 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Be Completed dob xrcoagu completion of cause of death? has tumor 1 Yes 2 No 1 Yes 2 No DRain Division of Vital 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpalient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth edical Certification: To this 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Hospital or Attending Pi 124 hours after death.
 Funeral Director: After the levely filled in by the funeral 1 Netural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide A 24 hou. 29e. Certifier 110 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. To the Within 2 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29¢. License number 0055997 s of person who completed cause of 8 ath (Item 23a) (Type, Print) HOLA DEBRA GALLO 6730 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rsv 6/95

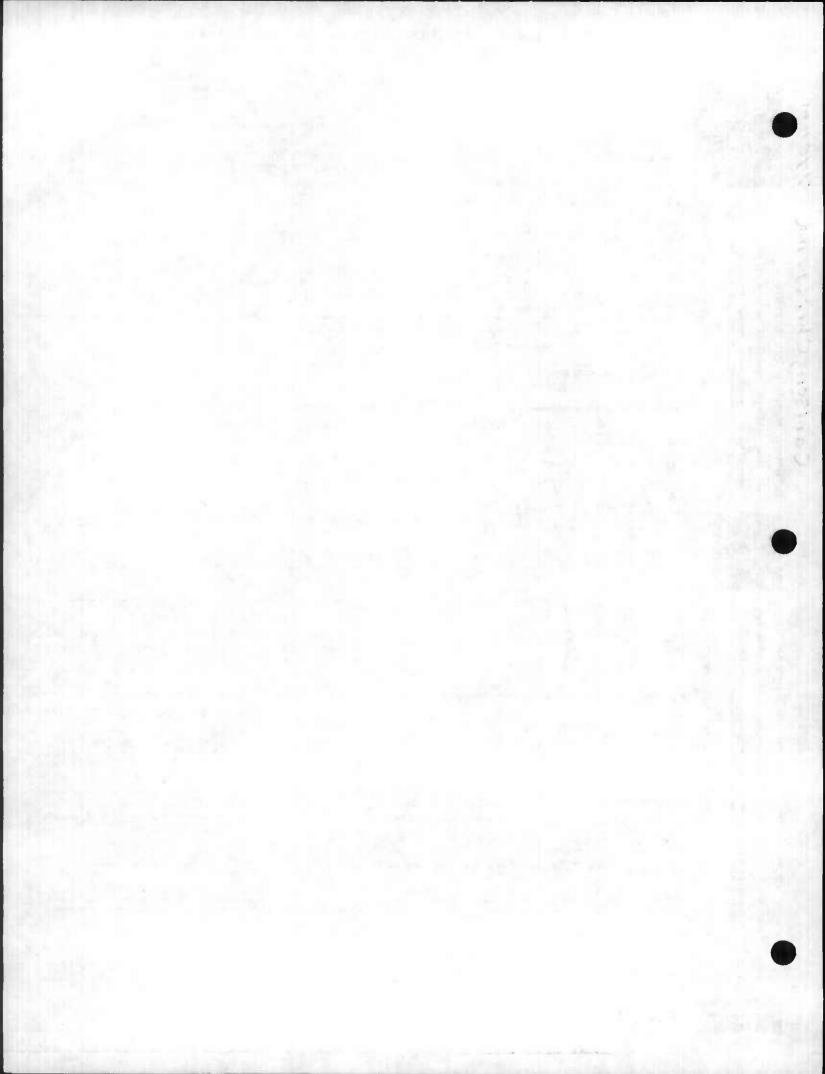
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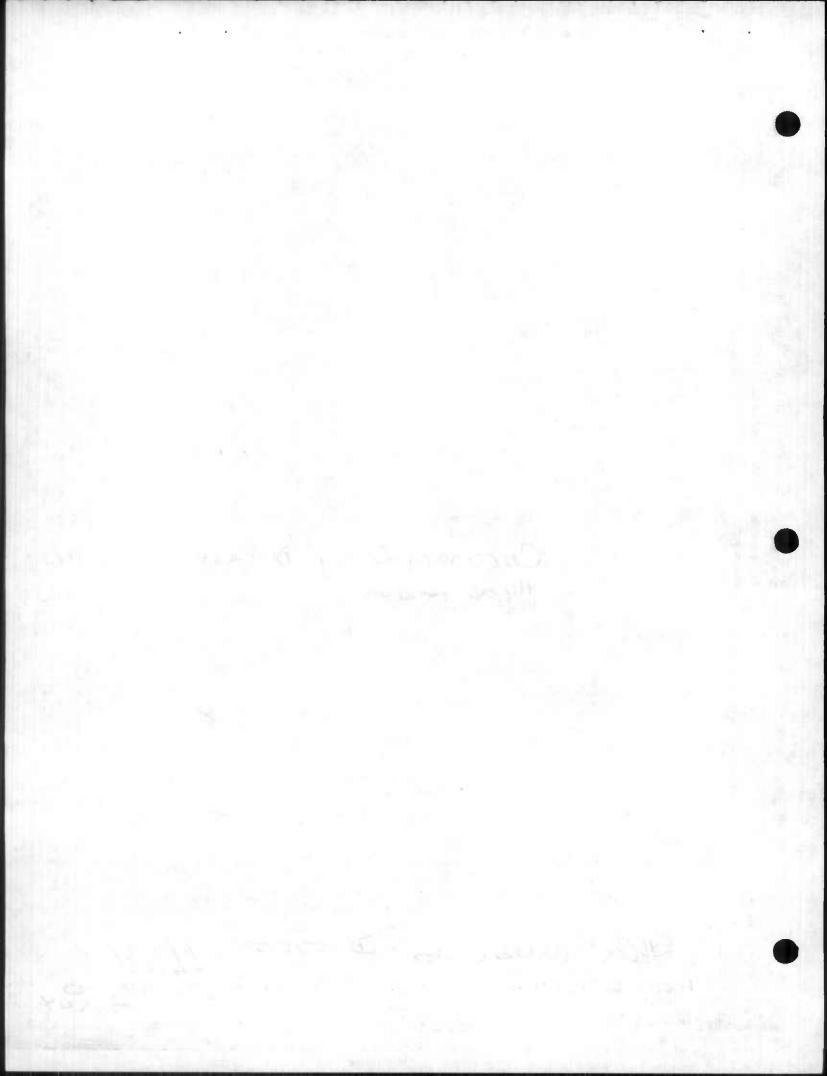
State of Maryland / Department of Health and Mental Hygiene 00 37229

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20. 14	Physician Christina L. Carlson November 2023 2000 of February 1000 of Febr											
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	disease or condition	Brei	95 T	CA	1C	er					10 yen	
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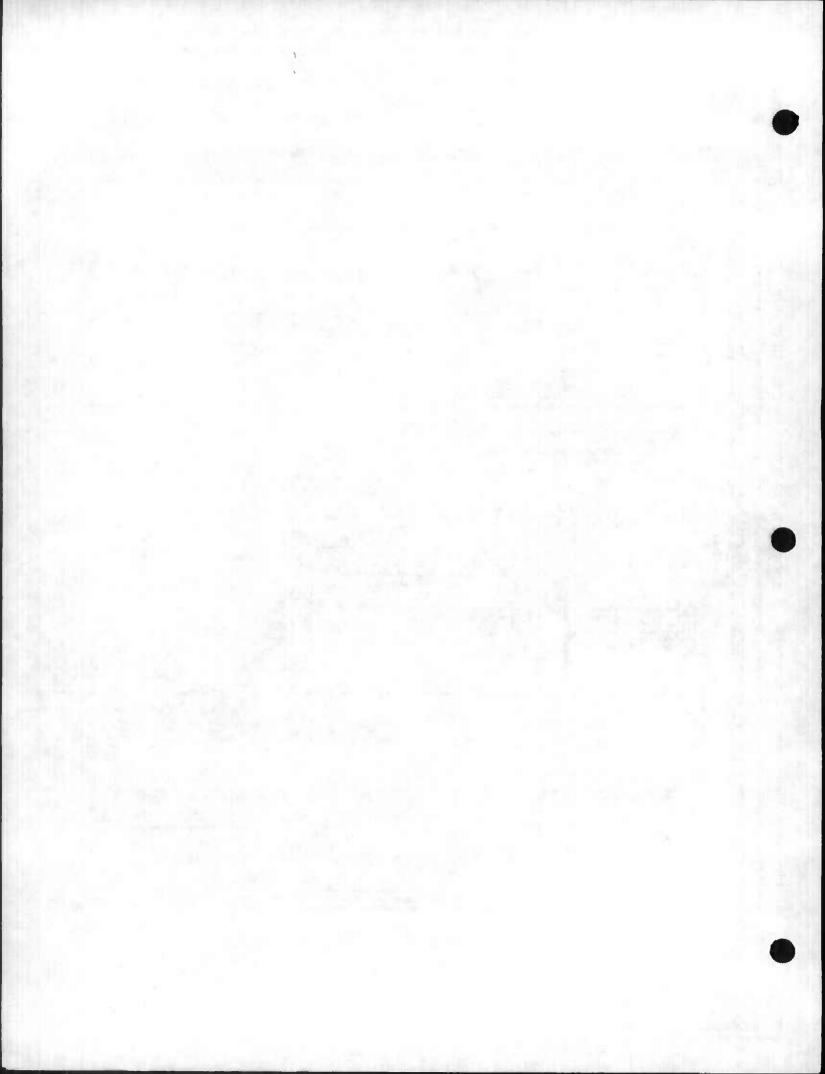
State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 2 3 0

				Certifica	ate of	Death			Reg. No.		, pm	
	1. Decedent's Neme (First, Middle,	Last)						2. Date of De		Year	3. Time of [	Death
Physician /Medical	Marjorie Cott	rill					- 1	11	21 2	2000	8:30	PM
Examiner	4h City Town of Localitation and standard and supplied							cation of Deeth	4c. County	of Death		
	8723 Valleyfield	Road				Luthe	rvill	.e	Baltin	nore		
Funeral Director	5. Social Security Number 127-07-3386	Sex 7. A	ge (In yrs. last bii 82	Yrs. If Unc	s Days		Min.	8. Date of Birt (Month, De 04/28/	3.0	9. Birthp Coun	place (State or	Foreign
-	Usual Residence of Decedent							04/20/	10 1/	16M A	Ork.	
show state	10a. State 10b. County		10c. City, Tow	n or Location						1	Od. Inside City	
o Ma	MD Baltimo	re	Lutherv	ille							1 Tes	2™ No
th with the Maryin 23s or 28s-f shor ust be notified at rai Director										√hat Coun	ntry?	
ter des tems foer m	11. Maritaf Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	Armed Forces	os 2 [™] No Give 1□ Yes 2 [™] No					city Yes or No Rican, etc.)	14. Rece - American Indian Black, White, etc.  Specify: white			
d 2 should be filed within 72 hours at thand Mental Hygiene. The marked other than "natural", or beamstic event, the Medical Exam To Be Completed by I	15. Decedent's (Specify only highest	Education	16a	Decedent's Us	sual Occu	pation	s of working	20	16b. Kind of Bu	siness/in	dustry	
5 cs G	Elementary/Secondary (0-12)	Coflege (1-4or	5+)	(Give kind of v life. DO NOT	use retire	iduning mos id)	1 OF WORKIE	,g				
d with a ser than a ser than a common of the s	12	2		inistra	ative	Assi	stant		Hopkins	Univ	ersity	
Be Getty	17. Father's Name (First, Middle, La	est)				18. Mothe	er's Name	(First, Middle,	Maiden Sumem	e)		
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and s	19a. Informant's Name/Relationship	o (Type, Print)	198	. Mailing Addre	ss (Stree	t end Numb	er or Rure	l Route Numbe	er, City or Town,	Stete, Zip	Code)	
and 2 selft is set tre	Robert Cottrill	/ son	87	23 Vall	leyfi	eld Ro	oad;	Luther	ville, M	4D 21	.093	
Pages 1 and the ref. If them into or other	20a. Method of Disposition  1 Burial 2 Cremation 3 Removel from State 4 Donatlon, 5 Other (Specify)  20b. Place of Disposition (Neme of cemetery, cremetory or other piece) Hilltop Service Corp  1 1/24/00 Towson, MD											
samit. Pages 1 a Department of Hei Important: If them sny Injury or other alice.	21. Signature of Fineral Service Licenses  22. Name and Address of Facility  1050 York Road  Ruck Towson Funeral Home, Inc. Towson, MD 21204											
40444	23a. Part1. Enter the disease, or or	llug	3 1000							son,	MD 21	204
examiner Examiner	Immediate Cause (Final disease or condition resulting in death)	Con	Due to (or as a	NO 821		y	Br	east	2		year	5
ng physicia as the bu	Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last											
attending for use	Death Other design			- M				l not pld		n dealth and a d	a Alba anuna a	d death?
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requires been sign should be									en eutopsy med?	av	ere autopsy fi raifable prior to impletion of ca death?	0
The lew ate hes page 2	4.47							10	Yes ZNO	1[	Yes 2	No
ician: The certificate rector, pag	25. Was case referred to medical					26. Piace	e of Deeth	(Check only o		_		
Physician: this certific rel director, TO Be	examiner?	Hospital:	ient 2 ER/O	utpatient 3	DOA O	hor	ursing Hor			er (Speci:	(v)	
2 5 7	27. Menner of Deeth Netural 5 Pending 2 Accident investiga	28a. Date of Inj. (Month, De	ury 28b.	Time of Injury	28c. Inju		2	ome Seridenca 6 Other (Specify)  28d. Describe how injury occurred				
or At sher of Direct in by	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Plece of In							Street end Numb vn, Stete)	er or Rure	el Route Numi	ber,
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Me Andrew	29b. Signature and title of certifier			1	29c. Licen	se number			29d. Dete signe	d (Month,	Dey, Year)	
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1 hay	20 Name and addition (	V COOK	death and	(Tuna Data)					11/00	4	20	
VI	30. Name and address of person w	no completed cause of	ueatt (Item 23a)	(Type, Print)	N	11	101	54	440	0.		
	21 Date filed (Marth Car V	1100	16)	1201	1, 4	na	ريد	7	Lonz	31	10	11
State Registrar	NOV 2. 7 2000	Services Services	rar's Signature	parks						7	150	7



State of Maryland / Department of Health and Mental Hygiene 00 37231

ASP			Ce	rtificate of	Death		R	eg. No.		
	1. Decedent's Nama (First, Middle, La	2	2. Data of Death Month Day Y			3. Time of Death				
Physician /Medical	MAXINE THERE			1	NOVEMBI		Year 2000	12:00 PM		
Examiner	4a Facility Name (If not institution, given		4b. City, Tov	wn, or Loca	ition of Death	4c. County				
Q	JOHNS HOPKINS HO	DSPITAL			BALTIN	MORE			N/A	
Funeral			rs. last birthday	Months Days		Min. 8	Data of Birth (Month, Day,			ace (Steta or Foreign
Director	223-04-5440	1□M 2kDF	41 Yrs.					1, 1959		**
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anyta anyta										
vith the Ma to 738-1 s be nout	MARYLAND N/A			BALTIM	ORE			0g. Citizen of W		Yas 2□No
Dire	10a. Street and Number			10f. Zip Coda			1	ry?		
death with the Manyland ma 23a or 28a-l show must be notified at neral Director	1826 N. BOND S	_		212	-					
	11. Marital Status	12. Was Decedant Evar in Armed Forcas?	0,5. 13.	Was Decedent of I If Yas, specify Cub	pan, Maxican,	in r (Specia , Puarto Ric	can, atc.)		- Amarica k, Whita, e	
1215-0020  within 72 hours after death with the Manylan ene. than "natural", or forme 23a or 28a-1 show he Medical Exeminet must be notified. Impleted by Funeral Director	1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2X No If Yas, Giva Yaar or Datas:		XXYas 2□ No	Specify:	Puerto	Rican	Specify:	HISP	ANIC
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1 21215-0 ed within 72 ho ygiene. her than 'nature ht, the Wedled Completed	(Specify only highest gra	ade completed)	(Give	kind of work dona DO NOT use retire	during most	of working				,
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	17. Father's Nama (First, Middla, Last	)			18. Mothai	r's Nama (/	First, Middla, I	Maidan Sumami		
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of He of He of He	20a. Mathod of Disposition	20b	. Place of Disp	osition (Nama of metory or other pla		- T		20c. Location -		
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Physician	shock, or neart tailurat. List only	ona cause on aach lina.	1		(.) 1				1	Onset and Death
/Medical	Immediata Causa (Final disaasa or condition	() ()	100	ille	Val	Man	ary	Thro	mos	emboli
Examiner	rasulting in death)	a. Dua to	(or as a conse	quance of):	-		(			
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oxecuted in and riel-transit	Sequentially list conditions,	b. Due to	(or as a conse	quance of):						
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C 68760, ntificate be executed ing physician and a as the bunal-transit Medical Examir	that initiated events rasulting in death) Last	C. Dua to	(or as a conse	quance of):						
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cords, P.O. B. v requires that the death been signed by the ette should be detached for leted by Physicia	Part II. Other significant conditions of	contributing to death but not re	asulting in tha	undarlying causa gi	ivan in Part I.		23b. Dfd to	bacco use con	tribute to	the cause of death?
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Record he law require he has been si age 2 should ompleted						1	24a. Was a perform		ava	ilable prior to
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After fune	1 Netural 5 Pending	28a. Data of Injury (Month, Day Year)		Wo	ork? ]Yas 2∐h		d. Dascribs in	JW IIIJOTY OCCUIT	ou .	
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die Propertie		nysician: To the best of my kenning: On the basis of examinand manner stated.								
Me Me	29b. Signature and the ocertifier		. N	29c. Licen	se number		2	9d. Data signed	(Month, I	Day, Year)
endho.	DI HOA	laver 1	(1-1)	o.c.	M.E		I	OVEMBER	R 20,	2000
V	30. Name and address of person who	completed onuse of death (to	em 23a) /Turn	Print\						
11/2	O.P. PO	I Wad	Me T	111 Penr	Stree	et. R	altimo	re. Mars	/land	21201
State	31. Date Illest (Month, Day, Year)	32. Registrar's Sig				, 5		- Dy LACES	,	-1101
Registrar	NOV 2 7 200	n hanna								
DHMH 16 Rev 6/95	4 7 7 11	1	10	Sport.	2 d					



Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Deta of Deeth 3. Tima of Death Month Year **Physician** Candido rmine Nov 22 00 a /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Bajti more
If Under 24 Hrs. 8. Date of Birth
Hours Min. 8. Date of Birth
Month, Day. 1 General
6. Sax 7. Aga 7. Aga (In yrs. las birthday) | Undar 1 Yaer 5. Social Security Number 6.5 Birthplaca (Stata or Foreign Country) **Funeral** Months Days 10M 20F 216-163283 Director Usuel Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits mast be notified at MD. ₩ Yas 2 No Funeral Director BATTMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 2/201 muklia ST SA 12. Was Decedent Ever in U.S. Armed Forcas? 12 Yas 2 □ No 174s, Giva Yaar or Datas; 7 4 3. ↓ ↓ 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 11 Merital Status Black, Whita, atc Never Married 2□ Married 1 Yas 2 No Specify: 6 WHITE Be Completed by 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Şecondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with nant of Health and Mental Hygiene. CONSTRUCTION BRICKLAYER NONE 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Neme (First, Middla, Last) AN DiDO Harl TRANO 194 Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code), or other tra IND TEUEHUN JAME altimore, 20b. Plece of Disposition (Nama of comatary, cramatory or others 20a. Mathod of Disposition /Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 Ramoval from Stata 5 Other (Specify) 22. Name and Addrass of Facility 21. Signature of Funeral Service Lice But 5-4661 a, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or raspiratory arrast, List only one ceusa on each lina. Entar tha diseas Approximeta Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in deeth) /Medical Examiner Dua to (or es a consequence of): Examiner tun gemi a picans Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disaasa or Injury that initiated evants rasulting in daath) Last The law requires that the death certificate be exec Box 68760. 141:45 Physician/Medical exiPh ena 15 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 | Yes 22 No 3 | Probably 4 | Unknown achexia Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? advance Dage 25. Was casa referred to medical axaminer? 1 Yas 2 No or Attending Physician: 26. Placa of Death (Check only ona) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

MA 1 Yas 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To this funeral 27. Mannar of Death 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No 24 hours after death. 2□ Accident invastigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 Homicida Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as steled.

| Certifying Physician: To the basis of examinetion and/or investigation, in my opinion, daath occurred at the time, deta end place, and due to the cause(s) and mannar stated. 29a. Certifiar (Check only one) To the 94 29b. Signatura and title of certifia 29d. Date signed (Month, Day, Year) INTERN NOV. 25, 30. Name and addrass of person who complated causa of daath (Item 23a) (Type, Print) Coneral Hospital Bosto, Infrior Williams MD. MD.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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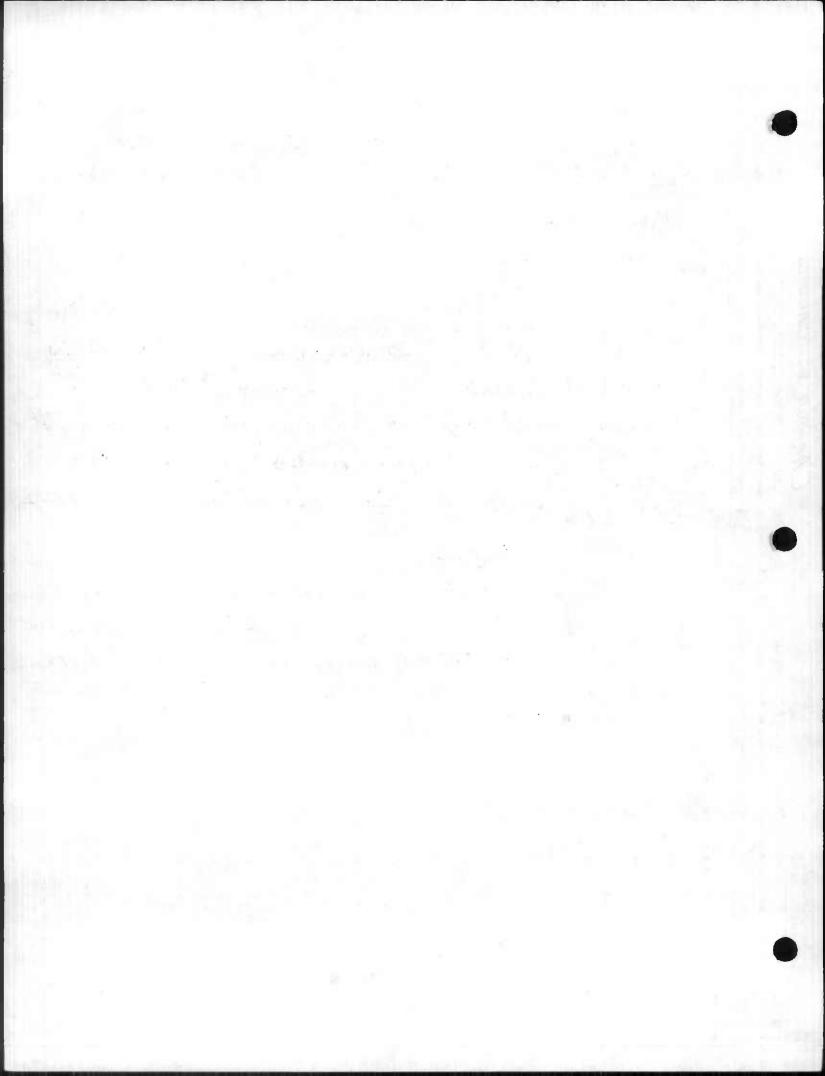
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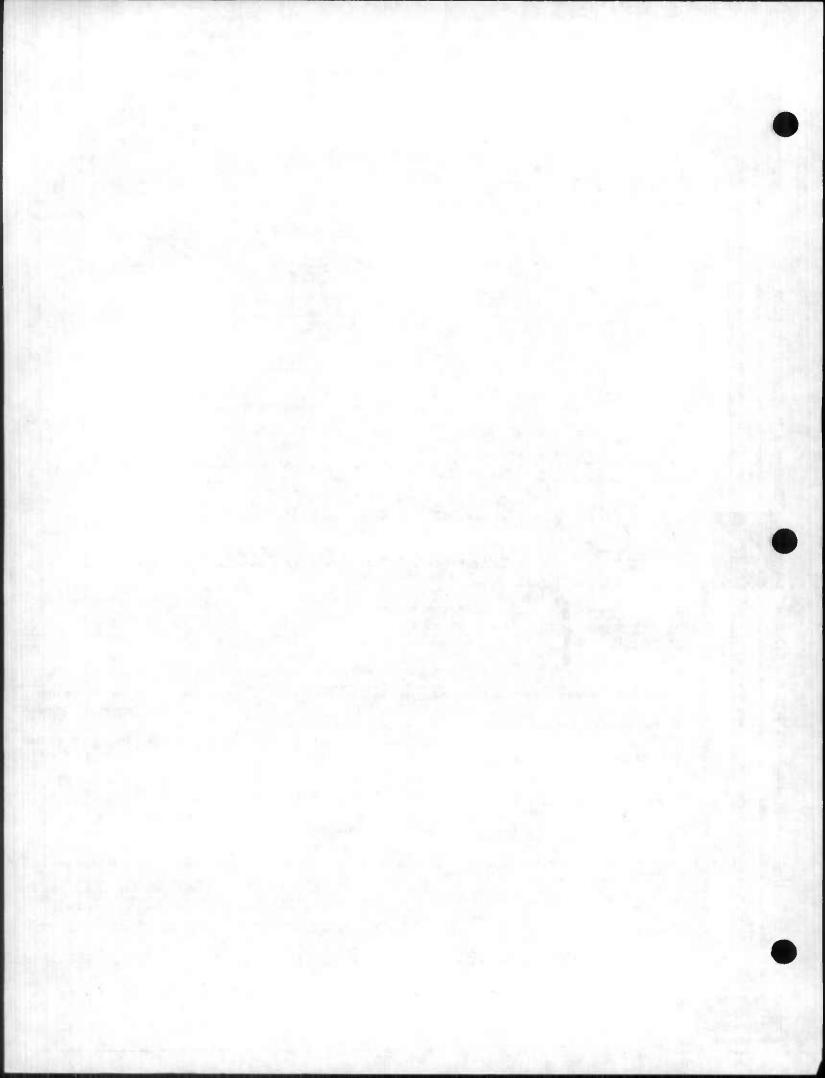
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32. Registrar's Signatura



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37233

	Certificate of Death	Rec	g. No.	01200
	Decedent's Nema (First, Middla, Last)	2. Data of Death		3. Tima of Death
Physician	MARY DEMBECK	Month /		000 4:00 m
/Medical Examiner	4a Facility Neme (If not institution, give street and number)  4b. City, Town, or Loc	cation of Death	4c. County of	
LAGITITIE	NOBLE HOUSE NURSING CENTER BALT		NI	4
		8 Data of Birth		
Funeral Director	2/4- /2- 2082 1 M 227 86 Yrs. Months Days Hours Min.	8. Data of Birth (Month, Day, Y		Birthplaca (State or Foraig Country)
pg .	10a. Stata 10b. County 10c. City, Town et location			10d. Inside City Limits
anyli anyli	MAN ALL.			1 Z Yes 2 □ No
ot die	MO N/A Dretmone			
with the Marylar a or 18a-f show be notified at Director	10e. Street and Number 10f. Zip Coda	100	g. Citizan of Wha	at Country?
E 23 P	+07 S. MILTON AVE. 21224		051	4
her death v r herre 23a inst. must Funeral	11. Marital Status  12. Was Decedant Evar in U,S. Armed Forcas?  13. Was Decedent of Hispanic Grigin? (Specific Yas, specify Cuben, Maxican, Puerto F	cify Yas or No-		American Indien, Whita, atc.
4 A M	1 Never Married 20 Merried 1 Yas 20 No Specify:		Specify:	rrings, and
Era.	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify.	AUCASIAN
natural disal	15. Decedant's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	16	6b. Kind of Busin	ness/Industry
The Man	(Specify only highest grade complated)  [Giva kind of work dona during most of workin life. DO NOT use ratired)  [Giva kind of work dona during most of workin life. DO NOT use ratired)	9	-	
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that the double event, Be C	17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama	(First, Middla, Ma	aiden Sumama)	
Menta Menta stic en To B	UNKNOWN NIEMCZYK UNK	KNOW	N	
od Mark	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addrass (Street and Number or Rural	I Routa Number, (	City or Town, St	ata, Zip Coda)
Day of the Control of	4		0 0	1 11x 211
Han Pan Pan Pan Pan Pan Pan Pan Pan Pan P	20a Mathod of Disposition 20b. Place of Disposition (Nama of	Data 20		y or Town, Stata
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Tan ba	4 Donation 5 Other (Specify)  3 Herenove Horn State  4 Donation 5 Other (Specify)	1/22	DACT	7.MO
E S S S S S S S S S S S S S S S S S S S	21. Signature of Funaral Sarvice Licensee  22. Name and Address of Fecility  KACZOROWSKI FU	WERAL K	HOME, 1	e.A.
88205	Euge To 1201 DUNDAUK A	to Ba	1 200 1	40 2122
	23a. Part 1. Enter the diseasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or shock, or heart failure. List prily one cause on each line.	r raspiratory arras	st,	Approximata
Physician	Shock, or near railura. List only ona causa on aach lina.			Intervel Batween Onsat and Death
/Medical	Immediate Causa (Final	-, -	7	
Examiner	Immediate Causa (Final disassa or condition a. Arteniesclaretic Cerenary Vacassa (Final disassa or condition a. Arteniesclaretic Cerenary Vacassa (Final disassa or condition)	· Vlar 6	)iscose	years
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executed in and hist-transit	b			
be executed telan and burial-transit	Sequantially list conditions, if eny, leading to immadiate cause. Enter Underlying			
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g physicia g physicia as tha bu	rasulting in death) Last  Dua to (or es a consequence of):			
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cien: The law requires that the death centrafficate has been signed by the attendinctor, page 2 should be datached for use.  Be Completed by Physician/M				
the the part of th	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i.	23b. Dld tob	acco usa contr	buts to the cause of deati
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as the game of the day	c by lessena			`
auld au		24a. Wes an		<ol> <li>Ware autopsy findings available prior to</li> </ol>
aw re is be 2 sho	Larynceal carcinoma			complation of causa of daath?
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cartif cartif Be	25. Was casa rafarred to medical axaminar?  Hospital: Other: Other: Other:			
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fter Inar	Natural 5 Panding (Month, Day Year) Injury Work?	28d. Dascribe how	v injury occurred	
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ar draw draw draw draw draw draw draw dr	3 Suicida 6 Could not be datamined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)	281. Location (Stre City or Town,	et and Number Stata)	or Rural Routa Number,
tal or Attending P rs after death. al Director: After t led in by the funare Certification:			of the said	
hour hour ly fill y	29a. Cartifiar 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	nd dua to the cau	usa(s) and mann	ar as stated.
n 24 hound n 24 hound no 54 ho	(Check only one)  2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurre and manner stated.	o at the time, dat	a and place, and	dua to tha cause(s)
To the Hospital or Attending Physician: The is within 24 hours after daath. To the Funeral Director: After this cartificate ha complataly filled in by the funaral director, page.  Medical Certification: To Be Com	29b. Signatura and titla of certifiar 29c. Licansa number	290	d. Data signed (	Month, Day, Year)
->-0	Markey Com Com 20117		10	24.5
10	1 17667		11-18	- 2000 l 21061
11)	30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)	. 0		0
( )	Michael ) I kwank 1310 Retail Hay Suite 508	Jon Pur	nie Mi	2106/
State	31. Data filed (Month, Cay, Year) 32. Registrer's Signature			
Registrar	MOV 2 7 2000 Depended to popular			

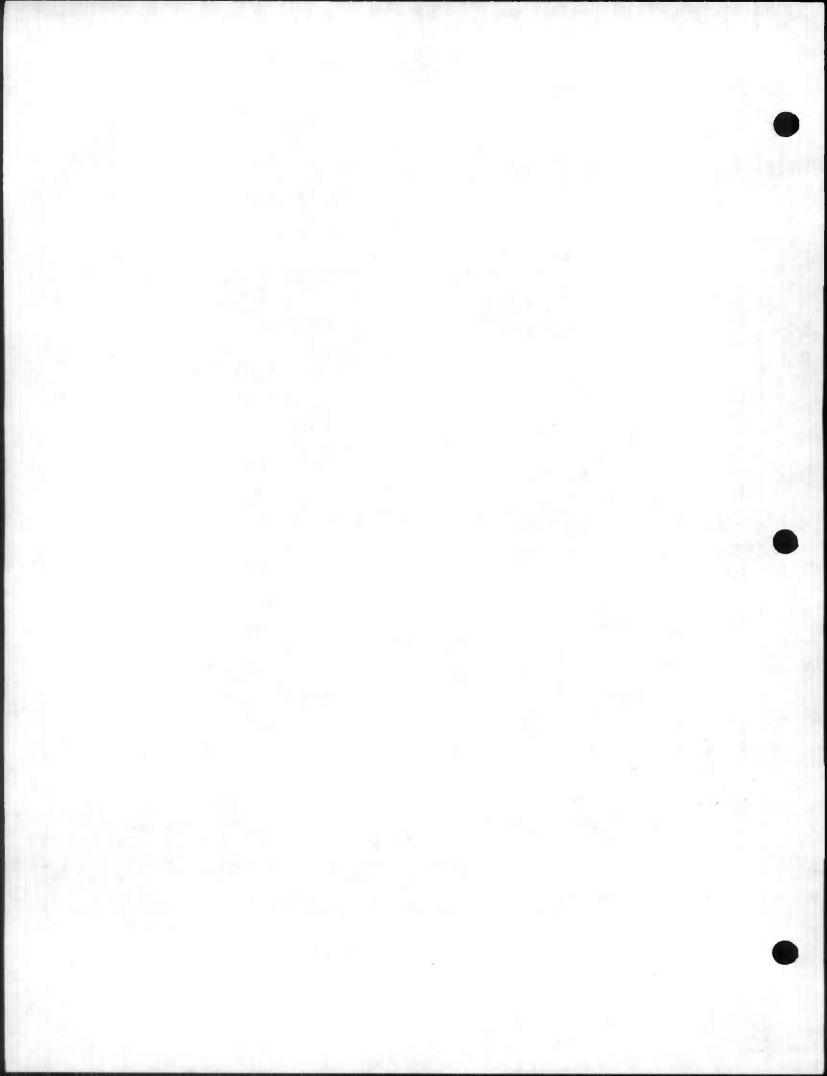


# LAWRENCE DUOLEY

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State of Maryland / Department of Health and Mental Hygiene O

	Decedent'a Name (First, Middle, L	ast)		Certificate	011	Death	2. Date of D			Time of Death		
ician dical	LAWRENCE DAVID DUDLEY						NOVEN	BER 16	2000	6:45PM		
er	4a Facility Name (If not institution, g	ive street end number)			-	4b. City, Town, or	Location of Dea					
		HOSPITAL		TER If Under	r 1 Venr	BALTIA If Under 24 Hrs		in the second se	NA	100-1-		
r	5. Social Security Number 6. 248 · 56 · 2518  Usual Residence of Decedent	Sex 7. Ag	e (In yrs. last bi	Yrs. Months		Hours Min		ay, Years	9. Birthplace Country)	(State or Foreign		
	10a. Sfate 10b. County	m or Location						nside City Limits				
ctor	mo N								1 ▼Yes 2 No			
Dire	10e. Streef and Number		10f. Zip	Code	- 20		10g. Citizen of V	Whet Country?				
Funeral Director	928 KEVIN RC	12. Was Decedent	Ever in U.S.	13. Was Deced	212 dent of H	1/29 lispenic Origin? ( an, Mexican, Pue	Specify Yes or N	o- 14. Rac	e - American In	ndian,		
Examiner.	1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No	If Yes, aped		an, Mexican, Puè Specify:	rto Rican, etc.)		ok, White, etc.  BLACK			
eted	15. Decedent's (Specify only highest of	Education trade completed)	168	Decedent's Usua (Give kind of wo	al Occup	petion during most of wo	orking	16b. Kind of Bu				
marked other than matur matic event, the Medical To Be Completed	Elementery/Secondary (0-12)	Elementery/Secondary (0-12) College (1-4or 5+)					1	TOMAR	PORTAT	700)		
	10 TH GRADE NA TRUCK DRIVER  17. Father's Name (First, Middle, Last)  18. Mother						me (First, Middl	e, Maiden Surnam				
To B	DAVID DUDLEY			San Tr		ALLEAN	ma	RAY				
	19a. Informant's Name/Reletionship		198	o. Mailing Address	s (Street			ber, City or Town,	State, Zip Cod	fe)		
other trac	MARGARET DUDL  20a. Method of Disposition	EY WIFE	20b. Place of	28 KEVII of Disposition (Nam	N Ki	D., BAL	Date	2 229 20c. Location -	City or Town	State		
	1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify)  Commetery, crematory or other plece)  KING MEMORIAL PARK							1-25-00 RANDALLSTOWN, MO				
	21. Signature of Funeral Service Lic	ensee		VAUGH	N C	GREEN NATI	PIKE B	ERAL SE	PRVICE 21229			
	23a. Part1. Enter-the diseese, or co shock, or heart failure. List on	mplications that caused by one cause on each li	d the deeth. Do	not enter the mod	de of dyin	ng, such as cerdia		errest,	Inte	oroximate erval Between		
	Immediate Cause (Final	Chanta				0 0 10.			Ons	set and Deeth		
r	disease or condition resulting in death)	a. SMALL		L LU/	NG	CARCI	NOMA		1011	MONTH		
ner			Due to for as a	consequence of):								
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or es e	consequence of):						Mary I		
ME	cause. Enter Underlying Cause (Disease or injury that initieted events	c				A = 181						
w.	reaulting in death) Lest		Due to (or as a	consequence of):								
and	MARK TO	d					156					
Physician/M	Part II. Other significant conditions	contributing to death b	ut not resulting i	in the underlying c	ceuse giv	ven in Part I.		/		causs of death?		
Ph								1 Vss 2 No 3 Probably 4 Unknow				
ed by										eutopsy findings ole prior to		
Completed							per	formed?	comple of deat	etion of ceuse th?		
Com							10	Yes 200 No	1 □ Ye	s 2 No		
Be	25. Was case referred to medical examiner?	Mosnitel: 4			0		eath (Check only	one)				
0 ::	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie				4 LI Nursing	1	how injury occur				
tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	28e. Date of Inju (Month, Da	y Year)	Injury M	28c. Injur Wor 1 □	rk? Yes 2 □ No	200. Describe	anjury occur	.50			
Medical Certification:	3 Suicide 6 Could not determine	ha	ury - At home, for a c. (Specify)	arm, street, factory					oute Number,			
0	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	f exemination er									
dica	one)	and manner St		1.00	a Linna	se number		29d. Date signe	d (Month, Day,	Year)		
Medica	29b. Signeture end title of certifier			290	C. Liceris							
Medica		e Sono	MD	290	P	14423			BER I	7, 2000		
Madica			MD leeth (Item 23a)		P	14423	^	NOVEMI		7, 2000		
1	29b. Signeture end title of certifier	DING 3	0015.		PIER	14423 STREE	T . BAL	NOVEMI		7, 2000		
The state of the s	29b. Signeture end title of certifier  30. Name and address of person who	DING 3			P .	14423	T. BAL	NOVEMI				



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Nov. 25, 2000 4:25AM Anna Mae Dunbar 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Baltimore 5520 Willys Ave. Arbutus If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country)
 MT 8. Dete of Birth (Month, Dev. Year) Min 1 M 2 TF Months Deys Hours 82 215-03-1441 Yrs. Dec. 26, 1917 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5520 Willys Ave. 21227 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indien 11. Maritel Stetus Bleck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hobby and Craft Machinist 8 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James A. Bush Mary Green 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1208 Biddle Pl. Catonsville, MD. 21228 Beverley Minnerly, daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete Loudon Park Cemetery 11-28-00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 21. Signeture of Funerel Service Licensee coles Doces 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediete Ceuse (Finel disease or condition resulting in death) 6 years stenosis Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? CHF, Mitral 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidenca 6 Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

þ

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at

Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hydiena.

Ant. If Item 27 is marked other then "natural", or items 23a or in yor other traumatic event, its ledge.

permit. Pages Department of Important: If it any injury or o

the Maryland

Physician/Medical Examiner use as þ Completed

Be

10

Certification:

edicai

attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ed by the a peed is certificate ha Physician: After this or Attending death. Director: / aftar To the Hospital o within 24 hours aff To the Funeral Di completaty filled in

State

25. Wes case referred to medicat 1□ Yes 2□ No 27. Manner of Death 1 Neturel 2 Accident 3 Suicide

4 Homicide

(Check only one)

29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

Maiden Choice

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

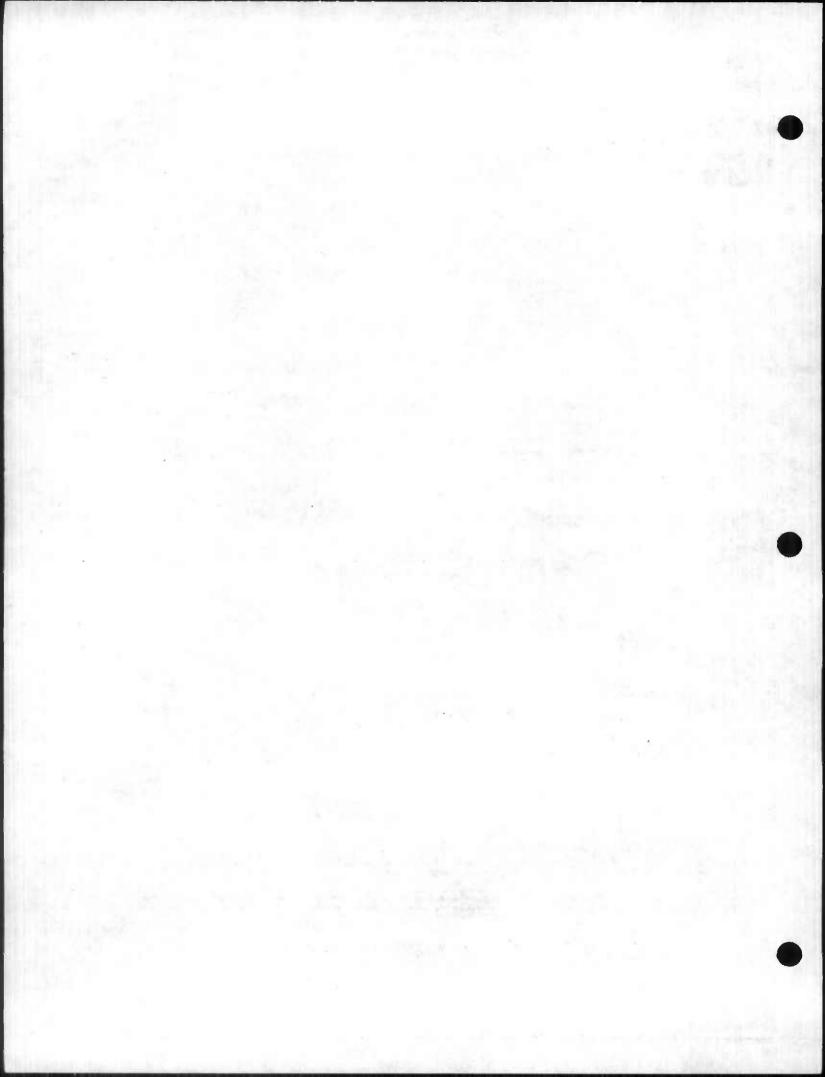
Lane Suite 101

32. Registrer's Signeture mysena

Baltimore

**DHMH 16 Rev 6/95** 

Registrar



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dixon 12 25 November 19 2000 Andrew 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth City Baltimore Johns Hopkins 7. Age (In yrs. last birthdey) | Winder 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) 1€10M 2□ F Months Deys Hours Min Yrs. 70 224-34-5008 Usuel Residence of Deceden 30 04 03 V.A 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1221 North Curley Street 21213 U.S.A. 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) XYes 2 No Yes, Give Yeer or Detes: 1 Never Merried MMerried 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 7th grade Laborer Bethlehem Steel Corp 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Clyde Elmore Dixon Martha Barbie 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Annie Dixon-Wife 1221 North Curley Street, Baltimore Md 21213 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Vet. 11/24/00 Owings Mills, Md 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility March F/H West Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or hear failure. List only one cause on each line. 4300 Wabash Ave, Baltimore Md 21215 Approximete Interval Between Onsel and Death Immediate Ceuse (Finel disease or condition resulting in deeth) ONE HOUR ACUTE MYOCARDIAL INFARCTION Due to (or es a consequenca of) CORONARY ATHEROSCLEROTIC

Due to (or es e consequence of): TEN YEARS TWENTY HYPERTENSION YEARS Due to (or es e consequence of)

**Physician** /Medical Examiner

The law requires that the death certificate be assecuted

or Attending Physician:

after death.
I Director: After in by the fu

within 24 hours a To the Funeral D completely filled Hospital

To the within 2 To the

Box 68760,

P.0.

of Vitai Records,

Division

Physician/Medical Examiner

À

Completed

Medical Certification: To Be

**Physician** 

/Medical

Examiner

10a. Stete

Directo

Funeral

à

**Funeral** 

Director

8 23m

21215-0020

Maryland

Saltimore,

Pages 1 and 2 should be nent of Health and Mental ant: If frem 27 is marked o

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last

use given in Pert f.	23b. Did tobacco use contribute to the cause of death?								
	1 Yes	2□ No	3 Probably	4 Unknown					

26. Place of Deeth (Check only one)

Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying car

24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 Yes 2 No

Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year)

28c. Injury et Work?

Other: 4☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

27. Menner of Deeth 1 Neturel 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be

1 Yes 2 No

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stele)

29a. Certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29b. Signeture end little of certifier lichman

NOVEMBER 19, 2000

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

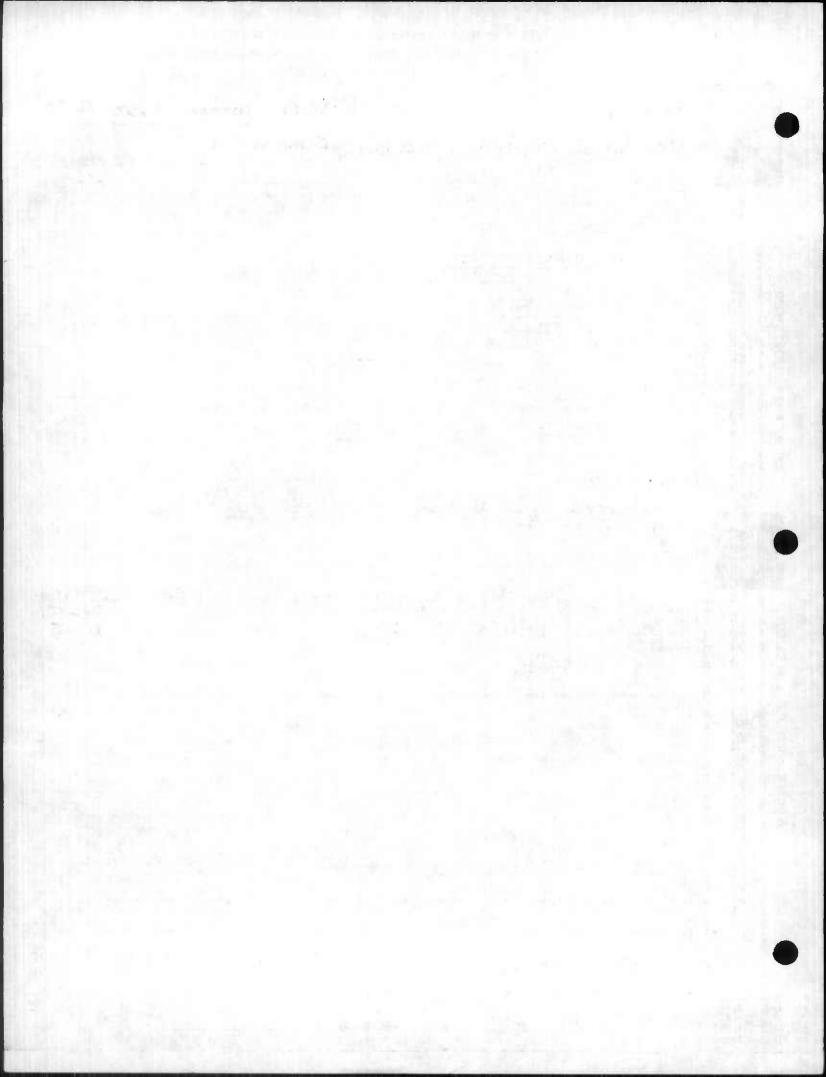
600 N. WOLFE 31. Dete filed (Month, Dey, Year) NOV 2 7 2000

BALTIMORE 32. Registrer's Signeture

M. D.

State Registrar

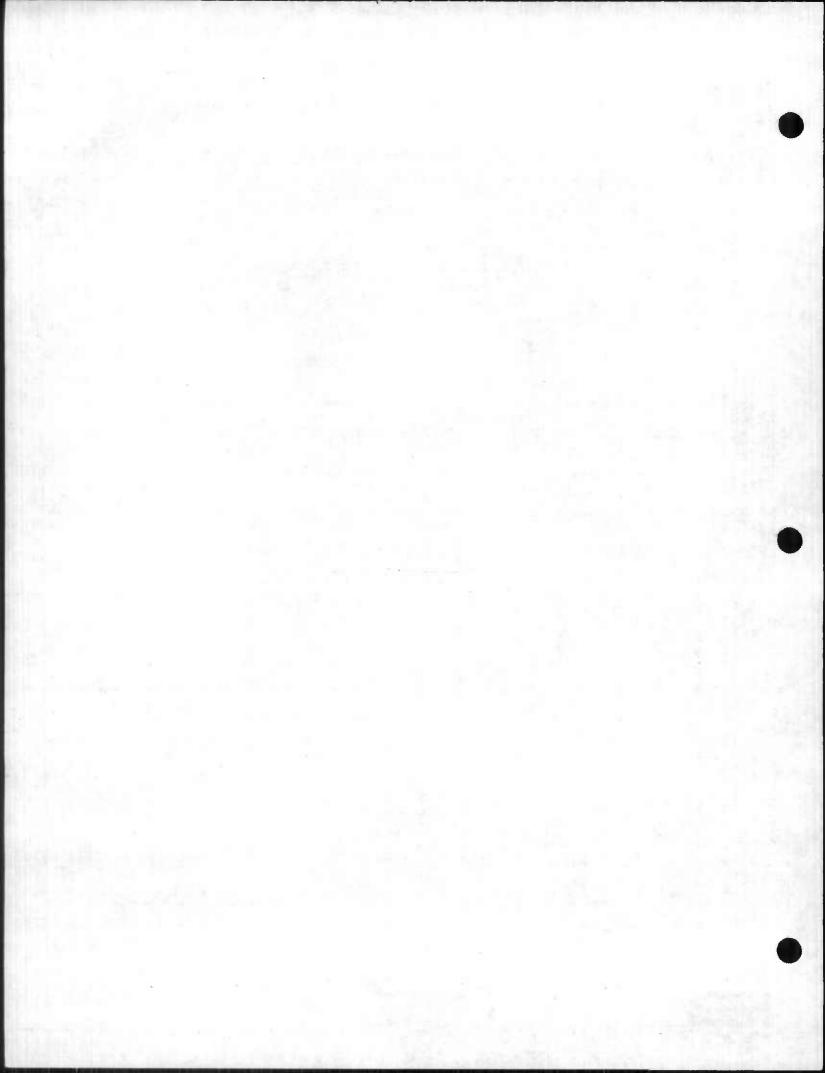
DRMH 16 Rev 6/95



DHMH 16 Rev 6/95

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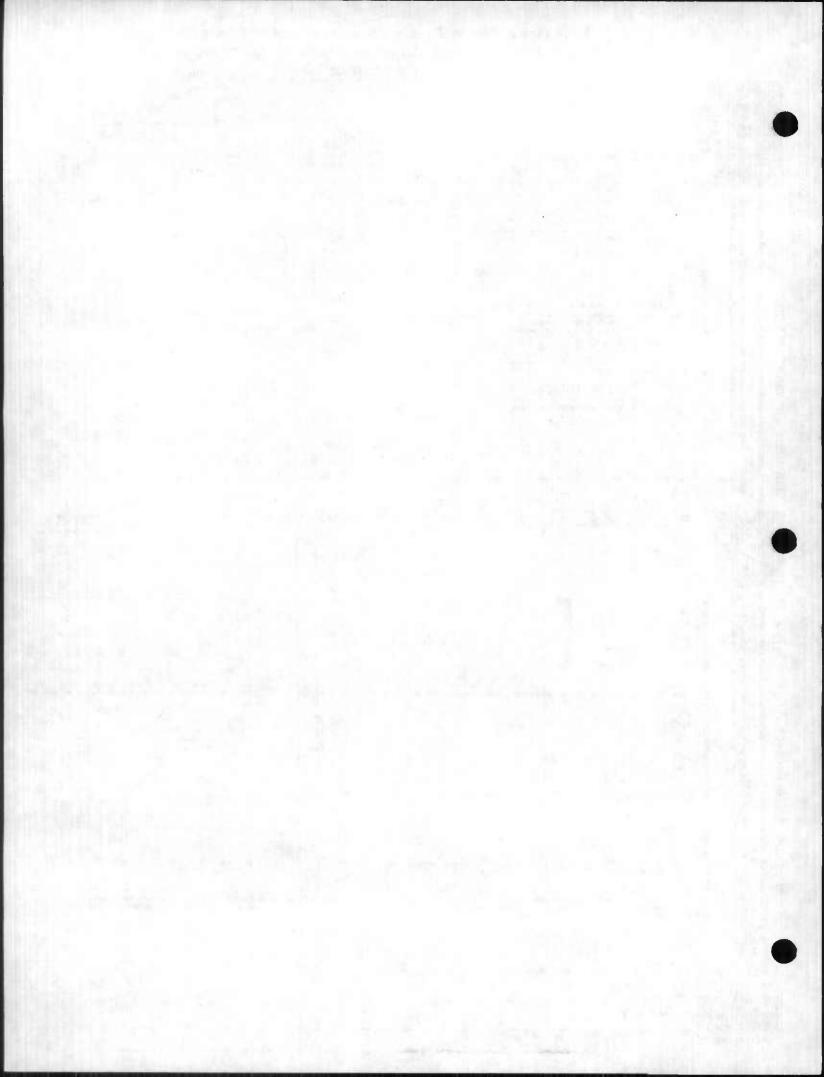
		Certifica	ate of Death	R	leg. No.	0 1 1						
1. Decedent's Name (First, Middle, Last)				2. Dete of Dea Month	th Dev	Year 3. T	Time of Death					
dical				November	24 :	2000 07:	:05 A.M					
1 4e Facility Neme (If not institution, give				4b. City, Town, or Location of Deeth 4c. County of Death								
10.110 1111 100	0th Street	: last birthday) If Unc		Dundalk Baltimore  1 Year   H Under 24 Hrs.   8. Dete of Birth Deys   Hours   Min.   Aug, 14,1951   Md.								
	M 2□F 49	in. (Month, Dey Aug,	14,195	9. Birthplace (Country) 1 Md.	State of Foreig							
10a. State 10b. County		ity, Town or Location					side City Limits					
Md. Balti	more	Dundalk		1 Yes 2								
	t.		Zip Code 21222		USA	Vhat Country?						
1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 ☐ Yes 2 No If Yes, Give Yeer or Detes:		pedent of Hispanic Origin? pecify Cuban, Mexican, Pu 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	Bled	e - American Ind ok, White, etc. White	dien,					
15. Decedent's Edu (Specify only highest grade (Specify only highest grade Elementery/Secondary (0-12) 8 yrs.  17. Fether's Neme (First, Middle, Last)	e completed)	16a. Decedent's Un (Give kind of the life. DO NOT	ual Occupation work done during most of v use retired)	working	16b. Kind of Bu	usiness/Industry						
8 yrs.	College (1-4or 5+)	Mechar	ic		Indus	trial						
17. Fether's Neme (First, Middle, Last)				Name (First, Middle,		(e)						
Robert Lee D	odd Sr.		Dorot	thy E. S	umlin							
19e. Informent'a Neme/Reletionship (Ty Marie Robier	pe, Print) sister		ess (Street and Number or .ftwood Ct.				)					
20e. Method of Disposition  1X Burial 2 Cremetion 3 R 4 Donetlon 5 Other (Specify)	amayal from State	Place of Disposition (A cemetery, cremetory o ak Lawn C	rother-leads	N2V00 ²⁸	20c. Location -	City or Town, S Lmore	tete					
21. Structure of Fundant Service Lipepter	2	Conne 7110	end Address of Fecility 211y Funera 5011ers Po	al Home	Of Dun 21222	dalk						
disease or condition resulting in deeth)  Sequentially list conditions, if any, leeding to immediate cause. Enler Underlying Cause (Disease or Injury that initialed events resulting in death) Last	).	(or es e consequence o	nf):	Cardio								
<u> </u>	d  Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I											
P P				_ 101	/ea 2□No	3 Probably	4 ☐ Unknov					
Completed				24e. Wes a	en autopsy med?	evaileble	atopsy findings a prior to ion of cause ?					
EOC				TELY	es 2 No	1 X Yes	2 No					
25. Was case referred to medical	lospitel:	☐ ER/Outpatient 3☐	011	Deeth (Check only only only only only only only only		er (Specify) S	rene					
	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h			ZETTE .					
27. Menner of Death  1 Selection  2 Accident  3 Suicide  4 Homicide  5 Pending Investigation  6 Could not be determined	28e. Pleca of Injury - At building, etc. (Spec	home, ferm, street, fect ify)	ory, office	28f. Location (5 City or Tow		per or Rural Rou	ite Number,					
29e. Certifier 1 Certifying Phys	ician: To the best of my kn ner: On the baals of examin end menner steted.						cause(s)					
29b. Signeture and title of centifier	4	1	29c. License number		29d. Date signe	d (Month, Day,	Year)					
n Hru	laver, P	1.0.	O.C.M.E.		Nove	mber 25,	2000					
30. Name and address of person who co	impleted seuse of death (Ite	_	Street, Bal	timomo W	arri and	21201						
1 1,103 CHV	I I I I I COM !	2 III Penn	DITEEL BAL	I IIIIO F IVI		/ / / / / /						



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ician	1. Decedent's Nem					2. Date of De	eth		3. Time of Deeth				
dical	Alice Heas	ley Dwi	ght						November	22°, 20	000 :	12:35 P.M.	
niner	4e Facility Name (		on, give stre	et and nur	nber)			4b. City, Town, or I Towson	ocation of Death		y of Deeth timore Co	o.	
al or	5. Sociel Security N 175-22-750	)3	6. Sex	21 <b>X</b> F	7. Age (In yr <b>7</b> 4	s. last birthday) Yrs.	If Under 1 Yeer Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bird (Month, De Feb. 20,	1926	e (State or Foreigungh, PA.		
or	Usuel Residence of 10a. Stete  Maryland	10b. Count	y Arundel	Co.		City, Town or Lo		10d. Inside City Limits 1 □ Yes 2 ②No					
Il Director	10a. Street end Nur Box 54 Cot		Road				10f. Zip Code 21	Code 10g. Citizen of What Count 21056 United States (					
but be filed within 72 hours after death with the Maryan Mental Hygiene.  The description of the state of 28s-f although other than "natural", or thems 23s or 28s-f although other than "natural be notified at after event, the Medical Exeminer must be notified at To Be Completed by Funeral Director	11. Meritel Stetus 1 Never Merr 3 Widowed		mied	Wes Dece Armed Fo 1   Yes If Yes, Giv Yeer or De	2 No		Wes Decedent of I If Yes, specify Cub	dispanic Origin? (S en, Mexican, Puert Specity:	ck, White, etc	- American Indien,			
	(Special Special Speci	15. Decede city only highe ondary (0-12)			-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)				ommuni ty	y College		
	17. Fether's Neme George Fra							18. Mother's Ner Hazel Coo		Meiden Sume	me)		
	19a. Informent's N Mr. Robert				nd)		_		or Rural Route Number, City or Town, State, Zip Code) ibson Island, Maryland 21056				
L. Pages 1 a tmant of He tant: If them qury or other	1 Rurial 2 Vi Cromotion 2 Demouslifrom State						of Disposition (Name of any, cremetary or other place)  p Service Corporation  Dete 20c. Location - City or Town, State 11/24/2000  Towson, Maryland						
	21. Signeture of Re	uneral Service	Licensee	Jeffre	y L. Ga	ir, Sr. 22	2. Name end Addre	ess of FecilityRuck	Towson F York Rd.				
edicai Examiner	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events  Due to (or es a consequence of):  Due to (or es e consequence of):  C											t month	
Physician/Medi	thet initiated events resulting in death) Last  Due to (or es e consequence of):  d												
een signed by the attending physicien and hould be detached for use as the burial-transfed by Physician/Medical Exan	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.								10	Y88 2 No	3 Probel	bly 4 Unkno	
Dy									24e. Wes	en eutopsy ormed?	avelle	eutopsy findings able prior to eletion of cause	
by									pend		OI Ge	eth?	
Completed by									10	Yes 2 No		eth? /es 2 No	
Be Completed by	25. Wes case referexaminer?	nae is made	el Hos	pital:			± 2□ DOA   Ot	her:	1□ ath (Check only o	one)	101	/es 2□ No	
To Be Completed by	examiner? 1   Yes 2   27. Menner of Deet 1    Netural	No th 5 ☐ Pendi	Hos	101	npatient 2 of Injury h, Dey Year)	ER/Outpetier 28b. Time of	f 28c. Inju	her:	1 □ ath (Check only of tome 5 □ Resi	one)	1 🗆 ther (Specify)		
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To Be Completed by	examiner? 1 Yes 2 2 2 27. Menner of Deet 1 Netural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only	No  5 Pendi invest 6 Could detent  1 Certifyi 2 Medica	Hos ing ingetion I not be mined ing Physici I Examiner	28a. Date of (Mont) 28a. Plece building	of Injury h, Day Year) of Injury - At ng, etc. (Spe best of my k sis of exami	28b. Time or Injury  home, ferm, strictly)	f 28c. Inju Wc 1 C reet, fectory, office on occurred et the tivestigetion, in my 29c. Licen	her: 4 Nursing h ny et nk? Yes 2 No me, date end plece opinion, deeth occu	ath (Check only of them 5 Residence 1 Residence 28d. Describe 28f. Location (City or Tologo, and due to the time,	one)  dence 6 NOt how injury occu  Street and Num wm, Stete)  ceuse(s) and m date and place	ther (Specify)  under or Rurel F  manner as state, and due to the	Hospic  Route Number,  ed. he cause(s)  y, Year)	

Alice Dwight November 22,2000 at 1235pm



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1. Decedent's Name (First, Middle, Last) .Physician /Medical **Examiner** 

MICHELLE A. ERDMAN

Michelle A. Erdman

Month NOV. 4b. City, Town, or Location of Deeth 3. Time of Death

4a Facility Name (If not institution, give street and number) 1900 ARWELL COURT

15, 2000 0046 AM

**Funeral** 

5. Social Security Number 6 Sax 1 M 201 F 218-78-2142

7. Age (In yrs. last birthdey) Yrs.

If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) APR.3,1960

2. Date of Death

9. Birthplace (State or Foreign MARYLAND

Director

notified at

must be n

or Rems

permit. Pages 1 and 2 ahould be filed within 72 hours after dea Dispatriment of Nealth and Mental Hygiene. Important: If Item 27 is treatised other in any Injury or other treatment of the 12 and 12

**Physician** 

/Medical **Examiner** 

as the bunal-transit

The law requires that the death certificate be executed

68760

Box

P.O.

Records.

of Vitai

Division

Physician/Medical Examiner

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Completed

Be

page

if or Attending P safter death.

I Director: After t d in by the funers

To the Hospital within 24 hours of To the Funeral Completely filled Hospital

Director

Funeral

þ

Completed

Usual Residence of Decedent 10a State 10b. County M.D. ANNE ARUNDAL

10c. City, Town or Location

40

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number

1522 MATTHEWTOWN ROAD

BUKNIE 10f. Zip Code 21076

10g. Citizen of What Country? U.S.A.

4c. County of Death

ANNE ARUNDEL

1 Never Married 2 Married

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

12th

Elementary/Secondary (0-12) College (1-4or 5+)

HAIR STYLIST

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

ALFRED S. WRIGHT

BERTINA HARRIS

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

ALFRED S. WRIGHT FATHER

20b. Place of Disposition (Name of cemetery, cremetory or other place

137 WESLEY AVE., BALTIMORE, M.D. 21228 20c. Location - City or Town, State

20e. Method of Disposition

1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

ST. REST CEMETERY

11/20

18. Mother's Name (First, Middle, Maiden Surname)

HARMANS, M. D.

21. Signature of Funeral Service Licenses

Herbert E. Keutter

22. Name and Address of Facility NUTTER FUNERAL HOMES INC. 2501 GWYNNSFALLS PKWY, BALTO., M.D.

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Gunshot Wound of Left Arm and Chest

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last

Due to (or as a consequence of)

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy tindings eveilable prior to completion of cause of death?

Approximate Onset and Death

1 Yes 2 No

Yes 2□ No

25. Was case referred to medical Yes 2 No

6 Could not be determined

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

28a. Date of Injury (Month, Dey Year) 5 Pending investigation 11-15.00

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

0046 A

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) AT SCENE 28d. Describe how injury occurred

5 Wheet shot 281. Location (Street end Number or Rural Route Number, City or Town, State), 900 Black Ar well Cf

Medical Certification: To 29a, Certifier

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) Street

(Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signeture end title of certified

29c. License number O.C.M.E 29d. Date signed (Month, Dey, Year) NOV. 15, 2000

but

30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

26. Place of Deeth (Check only one)

State Registrar

31. Dete filed (Month, Dey, Year) NOV 2 7 2000

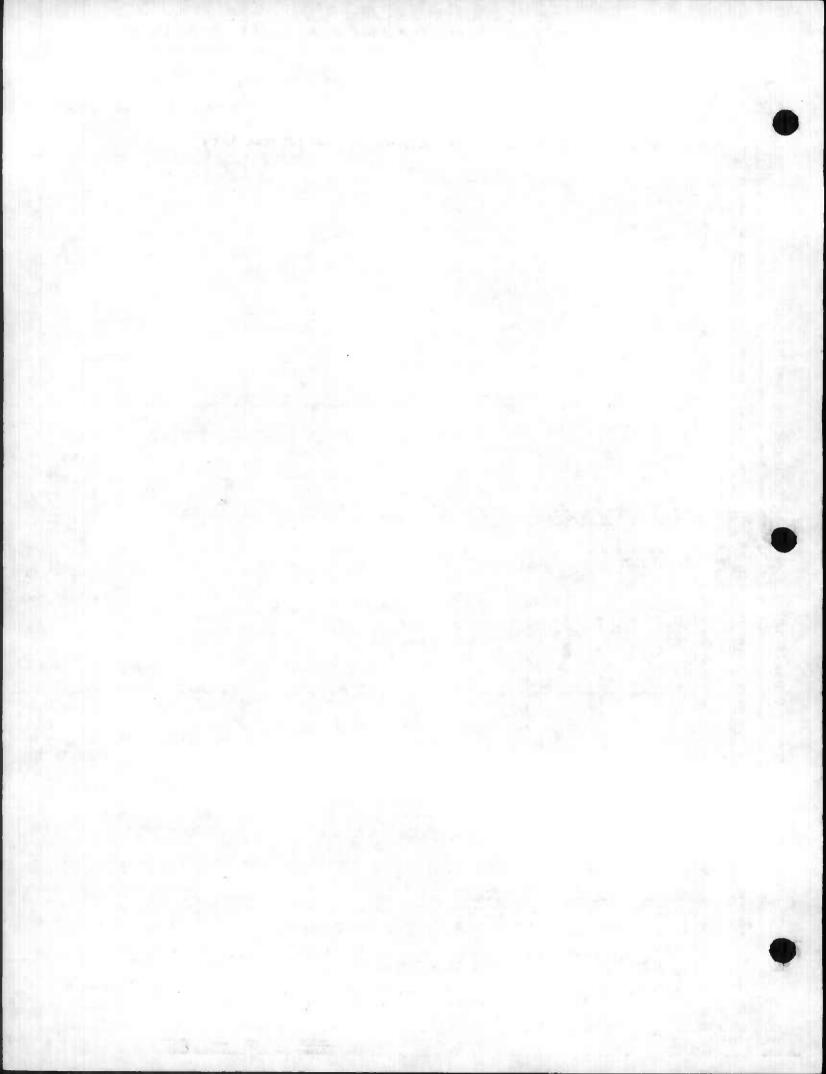
hutemo 32. Registrar's Signature

anakar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 2 4 0

			Cei	tificate d	of Death	R	eg. No.			
<b>D</b>	1. Decedent's Nama (First, Middle, Las	st)				2. Data of Deat Month		3. Time of Death		
Physician /Medical	William Hen	ry Eons	Jr			Novense		8440 600		
Examiner	4a Facility Name (If not institution, give	a street and number)			4b. City, Town, o	r Location of Death	4c. County of			
	R Admas Couler	2 Wock TRAN	as Con	HR.	Baldin	ure City	N/A			
Funeral	5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthdey)	If Under 1 Y	1 4 1 1 1 1		10	Birthplaca (Stete or Foreign Country)		
Director	215-60-5130 Usual Residence of Decedent	XM 2□F	48 Yrs.	MORTIS DE	iys Hours will		3 1952	MARYLAND		
or or 28a-f show be notified at Director	10a. Stata 10b. County  MARYLAND HARFO		City, Town or Lo	cation			10d. ir			
or 28a-1 or	MARYLAND HARFO	JRD	BELAIR	10f. Zip Coo	ie	1	0g. Citizen of Wh	at Country?		
	1705 AMYCLAE DRI	IVE			1015		U.S.A			
har death viner death viner matt	11. Marital Status	12. Was Decedent Ever Armed Forces?	In U,S. 13.	Was Decedent f Yes, specify (	of Hispanic Origin? ( Cuban, Mexican, Pue	(Specify Yas or No- orto Rican, etc.)		American Indian, White, etc.		
Maryland 21215-0020 d 2 should be filed within 72 hours after h and Mental Hygiens. 7 is merited other than "natural", or it traumatic event, the Medical Examin To Be Completed by Fu	1 □ Nevar Married 2 □ Married 3 □ Widowed 4 🖾 Mivorced	1 ☐ Yas 2\ No If Yes, Give Year or Datas:		1□ Yes 20X		H	Specify:	BLACK		
De caller	15. Decedent's Ed		16a. Deced	ient's Usual Oc	ccupation		16b. Kind of Busi			
1 21215-0 ed within 72 ho yglene. with than 'nature it, the Medical. Completed	(Specify only highast gra		(Give	kind of work do DO NOT use re	ona during most of w etired)	rorking	MARYLAN	D NATIONAL		
Parity and The State of the Sta	Elementery/Secondary (0-12) 12th grade	College (1-4or 5+)	LOA	N UNDER	WRITER		BANK			
D Hand	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, I				
yland Mental H Mental H whed off white ever	WILLIAM HENRY E	DDC CD			MARCA	RET D. GR	TEETN			
2 should man man a man a	19a. Informant's Name/Relationship (	-	19b Mailir	no Address (St	reet end Number or I			tate. Zio Code)		
Magaga Against										
da Taur	Floyd Epps/ Broth 20a. Method of Disposition	101	b. Place of Dispo	sition (Neme o	e Dr., Be			.UID ity or Town, State		
10 mm	1 ☐ Burial 2 💢 temation 3 ☐	Removal from State	cemetery, crer	netory or other	plece)	Dato	Loo. Loodion o	ny or com, otato		
Um Pa	4 □ Donation 5 □ Other (Specify		METRO CR	EMATORY		11-24-00	BALTIMO	RE, MARYLAND		
Battimore, permit. Pages 1 a Dopartment of Has Important: If them any injury or other ends.	21. Signature of Principal Service Licen	W Va	AM W	ILLIAM	ddrass of Facility C BROWN C		FUNERAL	HOME PA		
	23a. Part1. Entar tha diseasa, or comp shock, or heart feilure. List entry	pications that caused that	daath. Do not ent	er the mode of	ORTH AVEN	UE ac or raspiratory arr	est,	Approximate		
Dhuninian	shock, or heart feilure. List unity	one cause on each line.			, .			Interval Between Onset and Death		
Physician / /Medical	Immediate Cause (Final		75							
Examiner	diseese or condition resulting in death)	a	4212							
1		Due	to (or as a consec	quenca of):						
od sit		b								
Box 68760, deeth certificate be executed e ettending physician and ind for use as the burial-transit	Sequentially list conditions,	Due	to (or as a consec	juence of):						
68760, ficate be an physician is the burial edical E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c.								
68760, ficate be as physician is the buria	that initiated events resulting in deeth) Last	Dua	to (or as a conseq	uanca of):						
(D) 120 110 110 110										
Box seth cert for use		d		V 100						
the et hed for	Part II. Other significant conditions of	ontributing to death but not	t rasulting in tha u	nderlying cause	e given in Part I.	23b. Dld to	bacco use cont	ributa to the causa of death?		
- + >0						1 D Y	00 22NO :	3 Probably 4 Unknown		
or requirements						24a. Was a perform		24b. Were autopsy findings available prior to completion of cause		
I Rec The lew ate has b page 2 s								of death?		
- F # 8 0						1 🗆 Y	es 2 No	1 ☐ Yas 2 ☐ No		
Of Vital Physicien: The Physicien: The certificate ral director, page TO Be Co	25. Was case referred to medical axaminer?					eeth (Check only or	10)			
Of Vital Physicien: The this certificate ral director, part of this certificate ral director, part of the this certificate ral director random rate ral director rate rate rate rate rate rate rate rat	1 ☐ Yes 2 ☐ 110	Hospital: Theatient	2 ER/Outpatier			Homa 5 ☐ Reside	ence 6 Other	(Specify)		
E 5 5 6 C	27. Manner of Death  12 Naturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Yea	28b. Time of Injury		Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurre	d		
Division of Tothe Hospital or Attending P within 24 hours after death. To the Funeral Director: After toompletely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined			eet, factory, of	lice	28f. Location (S City or Town	treet end Number n, Stete)	r or Rurat Route Number,		
oltal Ce	20-0-45-									
he Hosp in 24 hot he Fune plately fil	29a. Certifier  (Check only one)  Check only one)	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, death mination and/or in	occurred at the vestigetion, in r	ne time, date and pla my opinion, death oc	ce, and due to the c curred at the time, d	ause(s) end men ete end place, er	ner as stated. nd due to the cause(s)		
Ne thing	29b. Signatura and title of certifier		- 13 13	29c. Lic	cense number	2	9d. Date signed	(Month, Dey, Year)		
	Masiem,	2.0		mi	4176025	63 22 1	Inco A.	20 24/10		
	100 m		(Itam CO.) /T	Drint)	-176 CA A 25'	1297 11	wender.	3000		
M	30. Name and address of person who of the binse		23a) (Type,	by Gre	4176435A	& Bajan	with 1	Maryland		
State [№] Registrar	31. Date filed (Month, Dey, Year)	32. Registrar's S	Signatura 6	han	the!					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year Clifton E. Fitzhugh 25, 2000 4c. County of Death 9:00 A.M. November 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Baltimore
If Under 24 Hrs. 8. D 1437 William Street N/A If Under 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Dev. Year) Min. Months Days Hours 1 MM 2□ F 216-16-0638 76 Feb. 28,1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1437 William Street 21230 U.S.A.

14. Race - Amarican Indian, 12. Was Decedent Evar in U.S. Armed Forces? 1 Mg Yes 2 □ No Hg Yes, Give Year or Dates: 1043. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, White, etc. 1 Never Married 25 Married 1 Tyes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 1943-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Water-Filler 6 Esskay Meat Packing Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Fitzhugh Ella Quimby 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Daisy P. Fitzhugh 1437 William Street, Baltimore, Maryland 21230 (Wife) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20c. Location - City or Town, State 1 ■ Burlal 2 □ Cramation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Park 11-27-00 Glen Burnie, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A.

130 E. Fort Avenue, Paltimore, Maryland 21230

Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, friterval Between Cheek, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Muelvid 4 month Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be

Examiner Box 68760. Moate be after 6

physician a # 980 ě Division of Vital Records, page 2 s Sid. B 24 hours

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show

a filed within 72 hours after de il Hygiene.
other than "natural", or them rent, in wedical European.

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe any Injury or other traumatic event, bace.

**Physician** 

/Medical

Examine

Physician/Medical

Š

Completed

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Certification:

edical

Director

Funeral

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the Maryland

death

To the To the To the F

State

Registrar

3 ☐ Suicida

29a. Certifier

4 Homicide

29b. Signature and title of certifier 29c. License number

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

D40854

29d. Date signed (Month, Day, Year) 27 2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Melcy Medical Center

3015+ Paul Place #407+ower Bidg BoHimore, MD 21202

32. Registrar's Signatura

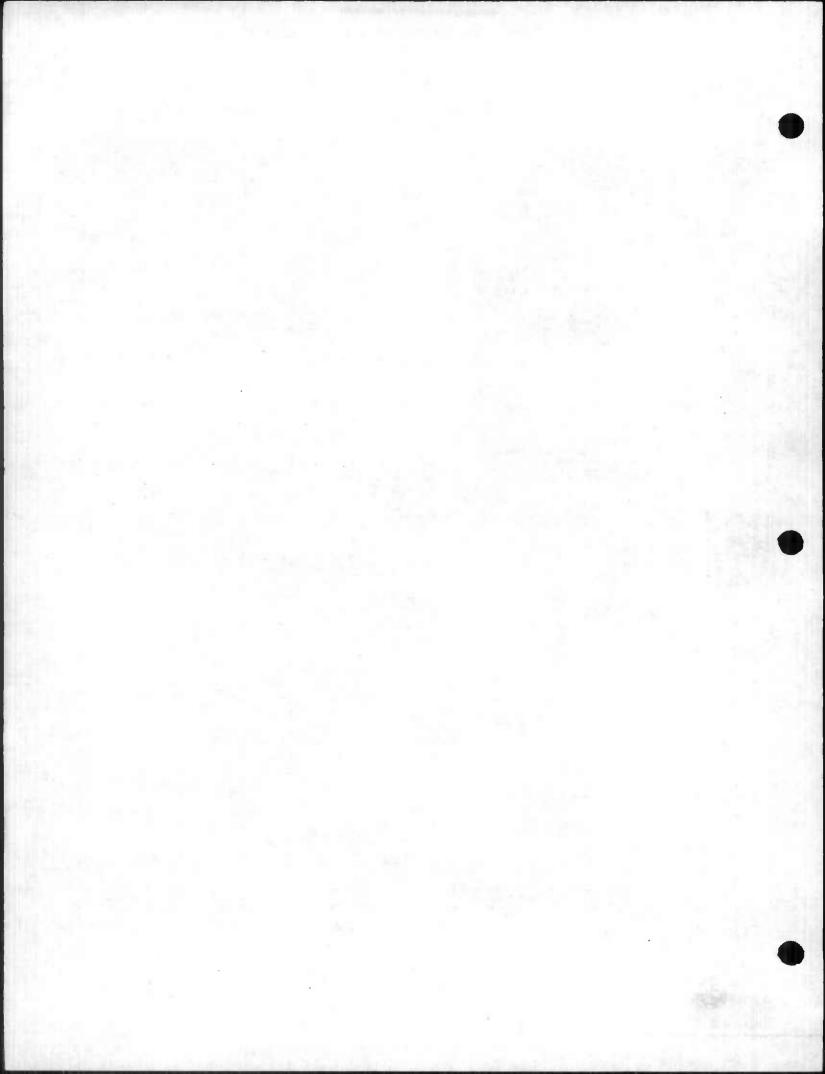
David A Riselog MD
31. Date filed (Month, Dey, Year)
NOV 2 7 2000

Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es stated.

(Check only one)

Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month November 18, 2000 12:25 PM Kenneth William Frank 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Severna Park Genesis Eldercare Anne Arundel If Under 24 Hrs. Hours Min. If Under 1 Yeer 8. Dete of Birth (Month, Day, Ye March 20 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 1907 Mary land Deys 1 1 M 2 □ F Months 93 Yrs. 216-16-6120 Usuel Residence of Decedent 10a Steta 10b. County 10c. City. Town or Location t0d. inside City Limits 1 ☐ Yes 2√ No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 1442 Maryland Avenue USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Yaar or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) Elementary/Secondery (0-12) College (1-4or 5+) Ship Yard Ship Repairman 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) William Frederica Fowble W. Frank 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Wesley Frank (grandson) 1442 Maryland Ave. Severn 21144 Nov. 21 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Glen Burnie, Maryland 21. Signeture of Funeral Service Land 22. Neme end Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122 he death. Do not antar the mode of dying, such as cardiac or respiratory arrest, 23a. Pert1. Enter the distance, or complications shock, or heert failure. List only one cause pproximate ervel Betwe Onset and Death Immedieta Cause (Final disease or condition resulting in death) 2 months Metastatic Liver Cancer Due to (or as a consequenca of): Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that initiated expects.) Due to (or es e consequence of): thet initiated events resulting in deeth) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 □ Yas 2 □ No 3 □ Probably 4 □ Unknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Was an autopsy 1 Yes 2√ No t ☐ Yes 2 ☐ No 25. Was casa referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No

**Physician** /Medical Examiner

Examin

Physician/Medical

à

Completed

Be

2

Certification:

edical

27. Menner of Deeth

1 Neturel

2 Accident

3 ☐ Suicida

29e. Certifier

4 ☐ Homicide

(Check only one)

**Physician** 

/Medical

Examiner

Director

by

Completed

Be

**Funeral** 

Director

8

72 hours after

filed within

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked other
any injury or other traumatic event

Baltimore, Maryland 21215-0036

in and Mental Hyglene. 7 is marked other than "hatural", or itsems 23s or 28s-f show traumedo event, the Medical Examinet must be polified at

s the burial-trans # 997 2 ĥ Deen certificate has egaq 4

certificate be exect Box 68760. Division of Vital Records, P.O. The law requires Physician: To the Hospital or Attending Programmer Villin 24 hours after death.
(To the Funeral Director: After the Compagale) illed in by the funeral

Registrar

29b. Signeture and fittle of certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

28a. Dete of Injury (Month, Dey Year)

D54736

Injury at Work?

1 Yes 2 No

November 21,2000

30. Neme and address of person who completed cause of eeth (Item 23a) (Type, Print)

7845 Okwood Road, Glen Burnie, MD. 21061 Dr. Kam AuYeung

28b. Time of

28e. Piece of Injury - At home, ferm, streat, fectory, office building, etc. (Specify)

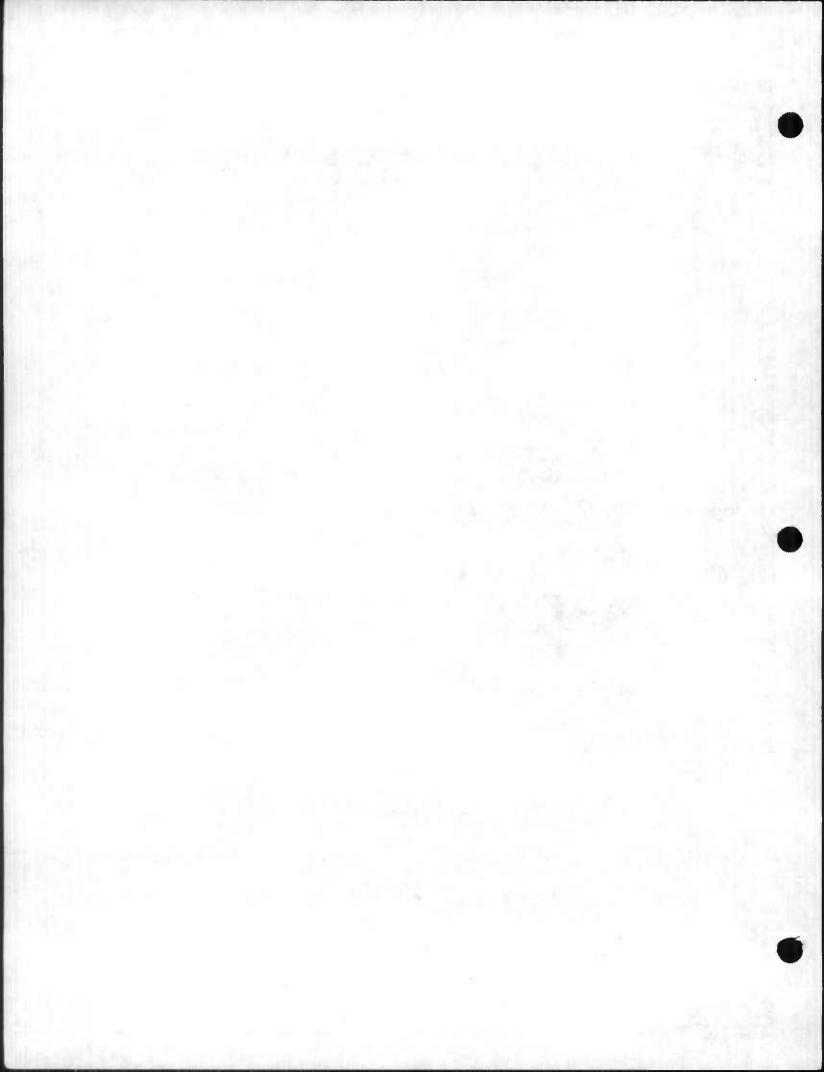
31. Data filed (Month, Pay

5 Pending Investigation

6 Could not be determined

32. Registrar's Signatura

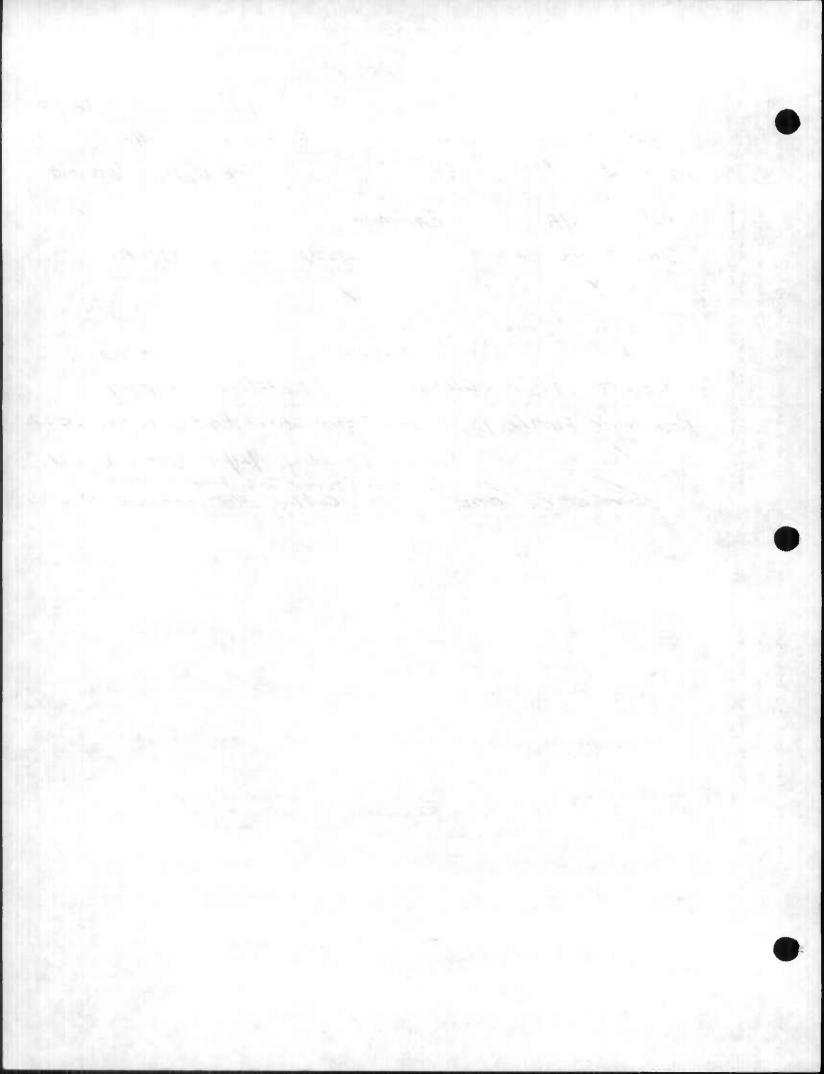




Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 3721, 3

			Ce	rtificate of	Death		Reg. No.		
	1. Decedent's Nema (First, Middle, La			19,50		2. Dete of De	eath Day	Yaar	3. Tima of Death
Physician /Medical	105/10/	Allen F	1etch	25		Novem	1 02	2000	12 p.m
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Emeral	5. Social Security Number 6. 5	Sax. 7. Age (In	yrs. last birthday)	If Undar 1 Yaar		Irs. 8. Date of Bi	rth 1	9. Birthple	aca (State or Foreigny)
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or 28e-f s be notified	10e. Street and Number	,	13471	10f. Zip Code			10g. Citizen of V	What Count	nv?
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aith e	Rosemarie Fl	etcher livi	FC 341	12 100%	ne str	ect. Bai	Himore	ma	1. 2/22
9 5 5	20e. Method of Disposition		Ob. Place of Disp	osition (Name of		Date	20c. Location ·		
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within 24 hours after death.  To the Funcel Director: After this certificate h comprehen filled in by the funeral director, page Medical Certification: To Be Con	25. Wes case referred to medical examinar?  1 Yes 2 No  27. Menner of Deeth  1 Natural 5 Pending invastigetion and suicide 4 Homicide 6 Could not be determined of the control one)  29a. Certifier 1 Certifying Procession one)  29b. Signature end title of certifier  30. Neme end address of person who	28e. Dete of Injury (Month, Day Ye  28e. Pleca of Injury building, etc. (S  nysician: To the bast of exe end menner steted.	At home, farm, st pecify)  At home, farm, st y knowledge, deel minetion end/or in (Item 23a) (Type	of 28c. Injunction of 28c. Injunction of 28c. Injunction of 15c. Injun	ther: 4 Nursing Nursing At Nursin	Deeth (Check only ng Homa 5 D Ras 28d. Describe 28f. Location City or To	sidence 6 Other how injury occurs (Straet and Numbown, State)  e cause(s) and men, dete end plece, 29d. Date signed	per (Specify red ber or Rura: enner as ste end due to	Yes 20 No  I Route Number,  eted. the ceuse(s)  Day, Year)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month V Paylette 17 2000 1050 AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Baltimore SECOUNS Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Manthe Days Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2XF Months Deys Hours Yrs. 214-54-7139 6/17/49 51 Baltimore, Md Usual Residence of Decedent 10b. County 10a Stata 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Baltimore N/A 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 2527 McHenry Street. USA 21223 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Never Married 2 Merried 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Soc. Security Admin. Government 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Wheatlev Ella Wheatley 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Ella Wheatley Mother 2527 McHenry Street, Baltimore, Maryland 2122 20a. Method of Disposition

1 Aburial 2 Cramation 3 Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stata Western Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 11/25/00, Baltimore, Md. 22. Name and Address of Facility Estep Brothers Funeral Ser, P.A. 21. Signeture of Funeral Service Licenses 1300 Eutaw Place, Baltimore, Md. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) neumania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? Multiple Myeloma 1 □ Yes 2 □ No 3 □ Probably 4 Unknown Pulmonary Amyloidosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

should be la markad

permit. Pages 1 and 2 sh Department of Health and Important: If hen 27 is m any injury or other treum 900ce.

Directo

Funeral

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Completed

Md.

Examine be executed attending physician and for use as the burial-tran Physician/Medical been signed by the should be detached should this certificate Be Certification: To

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apital or Attending Prouns after deeth.

neral Director: After the filled in by the funera To the Hospital of within 24 hours at To the Funeral D completely filled I

25. Wes case referred to medical axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

(Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier De, MD

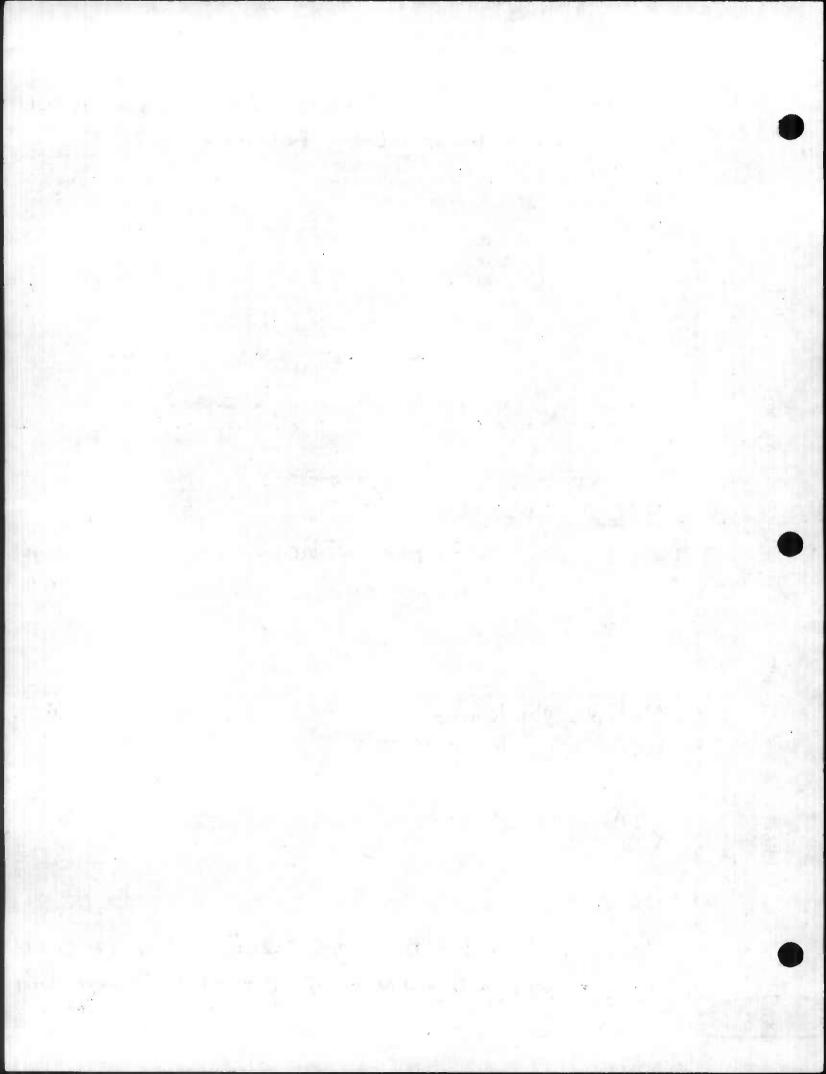
D0052940

EUtaw St #407, Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Shah MD, 821, N. Sanjay 2. Registrar's Signature

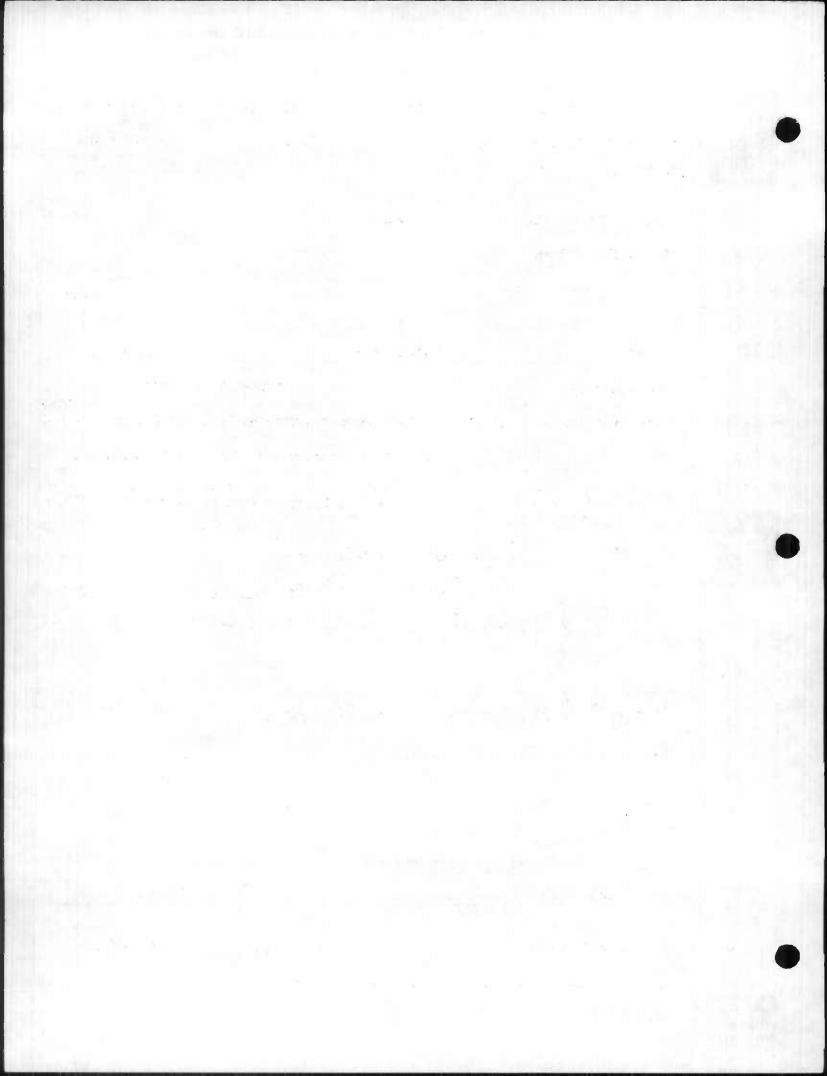
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 37245

					Certificat	e of	Death			Reg. No.			
		1. Decedent's Name (First, Middle, Last)  2. Date of										3. Time of Death	
ж	Physician	Gil	bert	Go	oldberg	ſ	Sr.	1	Novemb	Dey er 21.	2000	5:25pm	
	/ /Medical Examiner	4a Fecility Name (If not institut			Janery				ocation of Death 4c. County of D			J.23pm	
N.	Examiner	William Hill H	The second second				East	on	Talbot County				
-	Suggest	5. Sociel Security Number		Age (In yrs. lest bin	thday) If Under	r 1 Year	If Under		8. Date of Birt			-	
	Funeral Director	214-26-5519 Usual Residence of Decedent	11 M 2□ F		Yrs. Months	Days	Hours	Min.	8. Date of Bird (Month, De Jan. 09	y, Year) 1930	Maryl	ece (State or Foreign try) and	
	pue *	10a. State 10b. Cour	ity	10c. City, Town	n or Location					10d. Inside City Limits			
	Ba-f ehc	Md. Talk	oot County		Easton					1 ☐ Yes 2 No			
	be filed within 72 hours after deeth with the Maryland ral Hyglene. I dother than "natural", or items 23s or 28s-f ehow event, the Madical Examinat must be notified as Be Completed by Funeral Director	10e. Street and Number 501 Dutchmans	Lane		10f. Zip		21601			10g. Citizen of Whet Country? USA			
	ems une	11. Marital Status	12. Was Decede Armed Force	ent Ever in U,S.	13. Was Dece	dent of h	lispanic Ori an, Mexican	igin? (Spe	cify Yes or No		ce - America		
020	urs after Examination to by Fu	1 Never Married 2 M 3 Widowed 4 Moivorc	erried 1 X Yes 2	□No	1□ Yes		Specify:			Specif		white	
21215-0020	1 21215-002 ed within 72 hours ygiene. per than "natural; rt, the Massess Ex- Completed by	(Specify only high	ent's Education nest grade completed)		Decedent's Usu (Give kind of wo life. DO NOT u	al Occup ork done se retire	pation during mos	t of worki	ng	16b. Kind of B	usiness/Ind	lustry	
212	be filed within tal Hygiene. d other than event, the Manage Be Comp	Elementary/Secondary (0-12		College (1-4or 5+) 0 Carpenter						Arund	del Co		
	Hyg Hyg	17. Father's Name (First, Middle		, , ,			18. Mothe	er's Name	(First, Middle,	Meiden Sumer	ne)		
ylan		John Goldberg	9					Marg	aret N	Misczuk			
, Maryland	12 th	19a. Informant's Name/Reletion								ber, City or Town, State, Zip Code) 21171, 201 Pwings Mill Md.			
Baltimore,	5 to 1	20e. Method of Disposition 1 □ Burial 2 □ Crematio 4 □ Donation 5 □ Other		cemeter	Disposition (New ry, crematory or o Rosary	other ple		11/2	Date 5/2000	20c. Location Baltir			
Balti	permit. Peg Department Important: If any Injury o	21. Signature of Fluneral Service	to Licensee	1		ılly-	-Polyn	iiak		L Home I		21225	
	-	23a, Part 1, Enter the disease.	or complications that cau	ised the death. Do	not enter the mod	E. H	Pataps	cardiec o	ve. Ba.	Ltimore	, Ma.	21225 Approximate	
	Dh	23a. Part 1. Enter the diseese, shock, or heart failure. L	st only one cause on eac	h line.			or or or or					Approximate Interval Between Onset and Death	
	Physician / /Medical	Immediate Cause (Final	0.	2.1	60	0.						5 .10	
	Examiner	disease or condition resulting in deeth)										ZWOWS	
	<u> </u>	Due to (or as a consequence of):										1 2 2	
	mln min	La Constitution	b	wallon	run(	1/	V10 2	all	~		i	6 mus	
60,	physician end s the burlet-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
× 68760	M eng	thet initiated events resulting in death) Lasf		Due to (or es e o	consequence of):								
. Bo)	ettenc for us	Part II Other significant cond	tions contributing to dest	th but not resulting in	the underlying	na de de co	ven in Part I		23h Did	tobacco usa co	antribute to	the cause of death?	
P.0	ed by the deteched	Part II. Other significant conditions contributing to death but not resulting in the underlying carry given in Part I.								23b. Did tobacco use contribute to the cause of death  1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown			
S,	8 58 6		00010				* 4	0	040 14/00		24h We	ere autopsy findings	
Vital Records,	The lew requires that the sate has been signed by the page 2 should be deteched.	1000)							perfo	an eutopsy med?	cor	nilable prior to npletion of ceuse deeth?	
æ	The lev page 2								10	Yes 20 No	1□	Yes MiNo	
tal	certificate rector, pag	25. Was cese referred to medi-	cel				26. Place	e of Death	(Check only o	one)			
>	2	examiner?	Hospitel:	patient 2 ER/Ou	utpatient 3 Do	OA Oti	har			dence 6 Ott	her (Specify	()	
of	5 5 6	27. Manner of Deeth	28e. Date of			28c. Inju Wo		7		how injury occu			
0	oding F th.: After e funer	1 Natural 5 Pen	ding (Month, stigation	Dey rear)	njury M		Yes 2	No					
Division	tal or Attending P rs efter death. al Director: After I led in by the funer Certification:	3 ☐ Suicide 6 ☐ Coul	mined 286. Place of	f Injury - Af home, fa , etc. (Specify)	rm, street, factor	y, office			28f. Location (. City or Tot		ber or Rura	I Route Number,	
	To the Hospital or Attendation 24 hours either death within 24 hours either dost completely filled in by the Medical Certification.	(Check only 2 Medic	ring Physician: To the be al Examiner: On the basi										
	thin 2 thin 2 the mplet	one)	end menne	r staled.									
	ot with	29b. Signature and title of certi	- 10 0	1	208	C. Licent	se number	-	_	29d. Date signe	ou (monin, i	Day, Tear)	
	it.	- Walt	word,	4M1)		10	198	115		"1-	010		
	41	30. Name and address of person	on who completed cause	of death (Item 23a)	(Type, Print)								
	1	Dr. William W		utchmans 1	Lane Eas	ston	MD.	2160	)1				
	State Registrar	NOV 2 7 200		pistrer's Signature	Spork	in a							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37246 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Adam John Geyer, Jr. 3:35 AM November 23 2000 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) 1□ M 2\ F Months Deys Hours 85 Yrs. 215-18-3066 April 26 1915 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8820 Walther Blvd. #1301 21234 United States 12. Was Decedent Ever in U,S.
Armed Forces?
1 (X) Yes 2 () No
If Yes, Give
Year or Detes: WW Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced WW II 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) engineer business machines 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Adam John Geyer, Sr. Alma Bacon 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stefe, Zip Code) 21234 (wife) 8820 Walther Blvd. #1301 Parkville, MD Martha M. Geyer 20e. Method of Disposition
1 ☐ Buriel 2 ☑Cremetion 3 ☐ Removel from Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 11/25/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Mitchell-Wiedefeld Funeral Home, Inc. Twen (. Sottle 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) esophagent VAVicent Due to (or es e consequence of):

**Physician** /Medical **Examiner** 

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Completed

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Box 68760

P.O.

of Vital Records,

Division

after death.

within 24 hours To the Funeral completely filled

To the

permit. Pages 1 and 2 should be fit Department of Health and Merial He Important: If Item 27 is marked oth any Injury or other treatmetic even

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

s 23a or 25a-f a must be notified

Directo

AM JOHN GEVER JR - NOVEMBER Baltimore, Maryland 21215-0020, 3.35 AM

Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Physician/Medical

Due to (or es a consequence of)

Part fl. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert f.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 000 3 Probably 4 ☐ Unknown

24b. Were sutopsy findings aveileble prior to completion of ceuse of death? 24a. Wes en autopsy performed?

1 ☐ Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Netural 2 Accident

28a. Date of Injury (Month, Dey Year) 5 Pending Investigetion

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

"N. Charles St. Balto. md 21204

26. Place of Death (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

(Check only

3 ☐ Suicide

4 - Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) and manner steted.

29b. Signature and afte of optifie 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

6 Could not be determined

29c. License number

29d. Dete signed (Month, Dey, Year) November 23,2000

Registrar

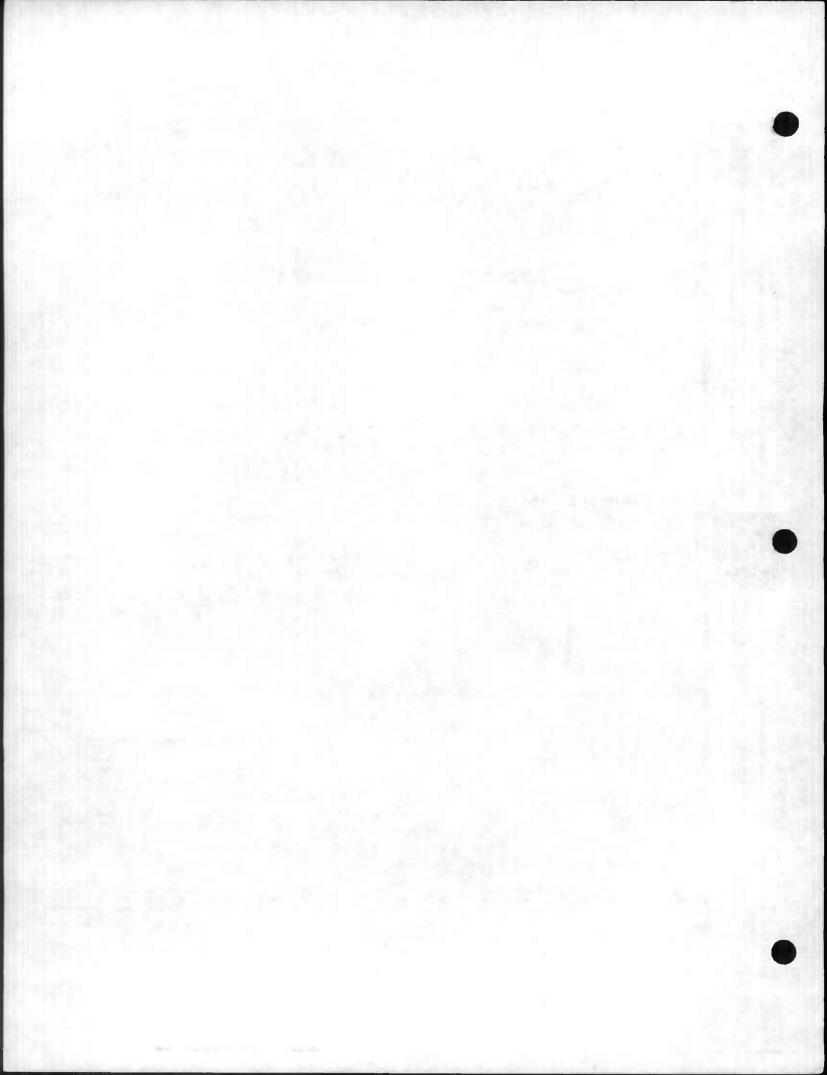
31. Date filed (Month, Day, Year) 2 7 2000

. A. Riles

GBMC 6701 32. Registrar's Signature

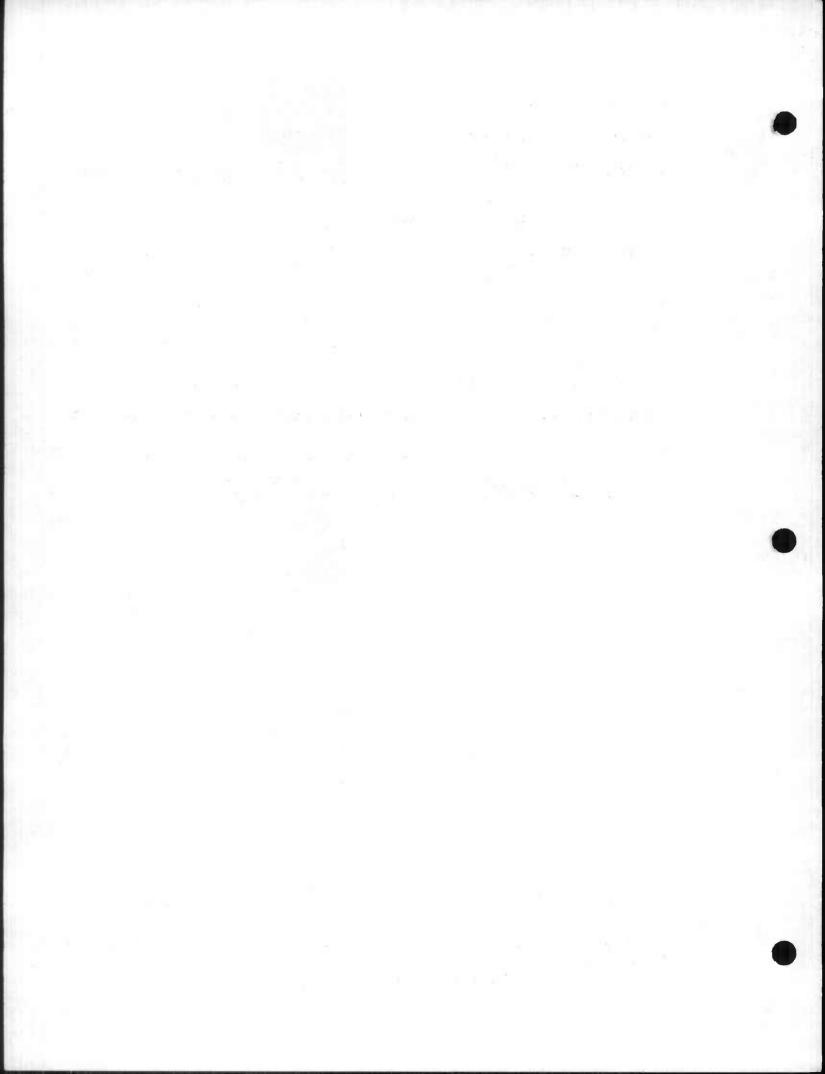
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DHMH 16 Rev 6/95



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2	Physici /Medic Examir	cal	Decedent'a Name (First, Middle, Last)     Ny R + LE Gu      4a. Facility Name (If not institution, giva s     UNION MEMORIAI				4b. City, Town, o	2. Data of Dea Month  COUCH  r Location of Death  RE CITY	Day	Year 2400 10:30 por Death		
	Funeral Director		5. Social Security Number 6. Sax 214 -24 -5089	M 224 7. Age (In yrs	s. last birthdey, Pg Yrs.	If Under 1 Ya Months Da	ar If Undar 24 Hr	s. 8. Date of Birt		Birthplaca (State or Foreign Country)     MD		
	hours effer deeth with the Maryland turet, or flema 23s or 28s-f show at Experiment must be notified at	Director	MD ANNE ARUN  10e. Street and Number	DEL (	City, Town or L				10d. Inside City Limi 1 ☐ Yes 2 1 N  10g. Citizen of Whet Country?			
020	in 72 hours efter deeth with the Marylan "natural, or Itema 23a or 28a-f show legical Expander must be notified at	by Funeral	563 ST MARY'S AV  11. Marital Stetus  1 Nevar Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever In U,S. 13. Wes Dec Armed Forces? In Yes. 2 1 No			of Hispanic Origin? ( Juban, Maxican, Pue No Specify:	Specify Yes or No- rto Rican, atc.)	USA 14. Race - American Indian, Black, Whita, etc.  Specify: WHITE			
21215-0020	and 21215- be filed within 72 hel Hygiene. d other than "nafeword, the Mode	Completed	15. Decedent's Educ (Specify only highast grede Elemantary/Secondary (0-12)	ation	(Give	dent's Usuel Oc a kind of work do DO NOT use rei AB TECH	na during most of w tired)	orking		PLASTICS PLANT		
Iryland		To Be	17. Father's Nama (First, Middla, Last)  JOHN E.  19a. Informent's Neme/Relationship (Tyx)	BRADY	19h Mail	ing Address (Str	LAURA		IPSON			
ore, Maryla				GHTER 20b.	571 Plece of Disp		IER DRIVE	Rurel Route Number, City or Town, Stata, Zip Code) ZEPHIR HILLS FLORIDA 33540  Date 20c. Location - City or Town, Stete				
Baltimore,	permit. Peges 1 end Department of Heelth Important: If Item 27 any Injury or other to 2002.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	GI	HOME P.A							
ox 68760,	Care the death certificate be executed by the ettending physician and by the ettending physician and deteched for use as the burlei-transit	n/Medical Examiner	23a. Part1. Entar the disease, or complic shock, or heart failure. List only on Immediate Cause (Final diseasa or condition resulting in deeth)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Lest	a or condition g in deeth)  Due to (or es a consequence of):  Due to (or as a consequence of):						Approximata Interval Between Onset and Death  Folker  Flogger  Flogger		
Is, P.O. Box	8 8 8	by Physician/M	Part II. Other significant conditions cont	ributing to death but not re	esuiting in the u	inderlylng causa	givan in Part I.	101	res 27 No	stribute to the cause of death?  3 Probably 4 Unknown		
Il Record	The law ate hes b page 2 s	Completed						24a, Was perfo	an autopsy rmed? 'as 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No		
Division of Vital Records,	nding Physician: The iseth. eth. w: After this certificate he funeral director, page	To Be	27. Mannar of Death Natural 5 Pending a housing invastigation	Ospital: 1 Ainpatient 2 Dispital: 28a. Date of Injury (Month, Day Year)	□ ER/Outpatie 28b. Time o Injury	of 28c. I	Other:	eath (Check only of Home 5 Resk 28d. Describe t				
Divis	spital or Atte ours after de eral Directo filled in by ti	al Certification:	3 Sulcide 4 Homicide  6 Could not be determined	28e. Plece of Injury - At building, etc. (Specials: To the best of my kn	eify)			City or Tow	m, Stete)	er or Rural Route Number,		
	To the Hospital or Attending PP within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only one) 2 Medical Examination one) Medical Examination one) Medical Examination one)	er: On the basis of axamin and mannar stated.	ation and/or in	29c. Lic	anse number	curred et the tima,	deta and piece, a	Ind due to the cause(s)  I (Month, Dey, Year)		
	Sta Registr	_	30. Name and eddress of person who cor  LATA E  31. Date filed (Month, Dey, Year)  NOV 2 7 2000	The state of the s		Print)	BRITIP	e pe io	to SPIT	88, 24 00 AL		



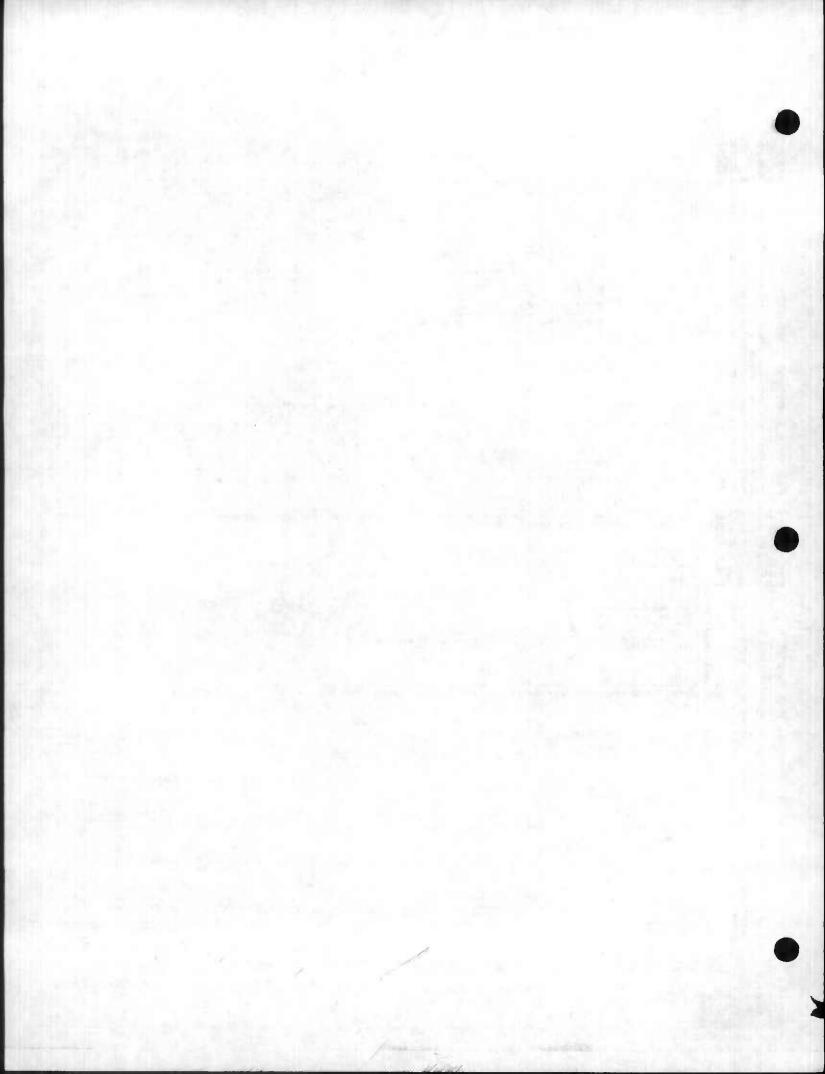
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** 2000 MARINA LYNN GREEN NOV. 10:05 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE COUNTY BALTIMORE GILCHRIST CENTER If Under 1 Yaar If Under 24 Hrs.
Months Deys Hours Min. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Months 10 M 20 F 45 216-66-6339 Director MAY 28, 1955 Maryland Usual Rasidence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Example: must be notified at 1 Yas 2000 Maryland Baltimore Baltimore County **Funeral Director** 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21286 USA 912 Breezewick Rd. 12. Was Dacedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 DNo If Yas, Giva Yaer or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, atc. 1 Nevar Married Merried 1 Yas XX No Specify: White Baitimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Flemantary/Secondary (0-12) 12 yrs. College (1-4or 5+) Via Waye Travel Travel Agent 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) 2 should be fi Angeline Maggio Robert Joseph Smith, Sr. 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 end 2 st Department of Health and Important: If Item 27 ia m any Injury or other traum Mr. Rob Green (Husband) 912 Breezewick Rd. Baltimore, Maryland 21286 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta Burial 2 Cramation 3 Ramoval Irom Stata
Donation 5 Other (Specify) 11-27-2000 Baltimore, Maryland Dulaney Valley M. G. 21. Signatura of Funaral Sarvice Licenses Lassann Address of Facility Home schard be 21236 7401 Belair Rd. Baltimore, Maryland 23a. Part f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner the attending physician and ched for use as the bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immediata ceusa. Entar Underlying Cause (Disaese or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed by Division of Vital Records. þ 24b. Wara autopsy findings evailable prior to complation of causa of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yes certificata 25. Was casa ratarred to medice! examiner? 89 26. Placa of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 10 this 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 27. Mannar of Death 28b. Tima of is or Attending P safter deeth.
I Director: After to d in by the funers 5 Pending 1 Natural 1 Yas 2 No Invastigation 2 Accident 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifiar Medical and manna#stated 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of 29c. Licansa number , uno addrass of person who completed cause of death (Nem 23a) (Type, Print) Charles St. Balto. md 21204 670 32. Registrar's Signatura State 2000 Registrar

**DHMH 16 Rev 6/95** 

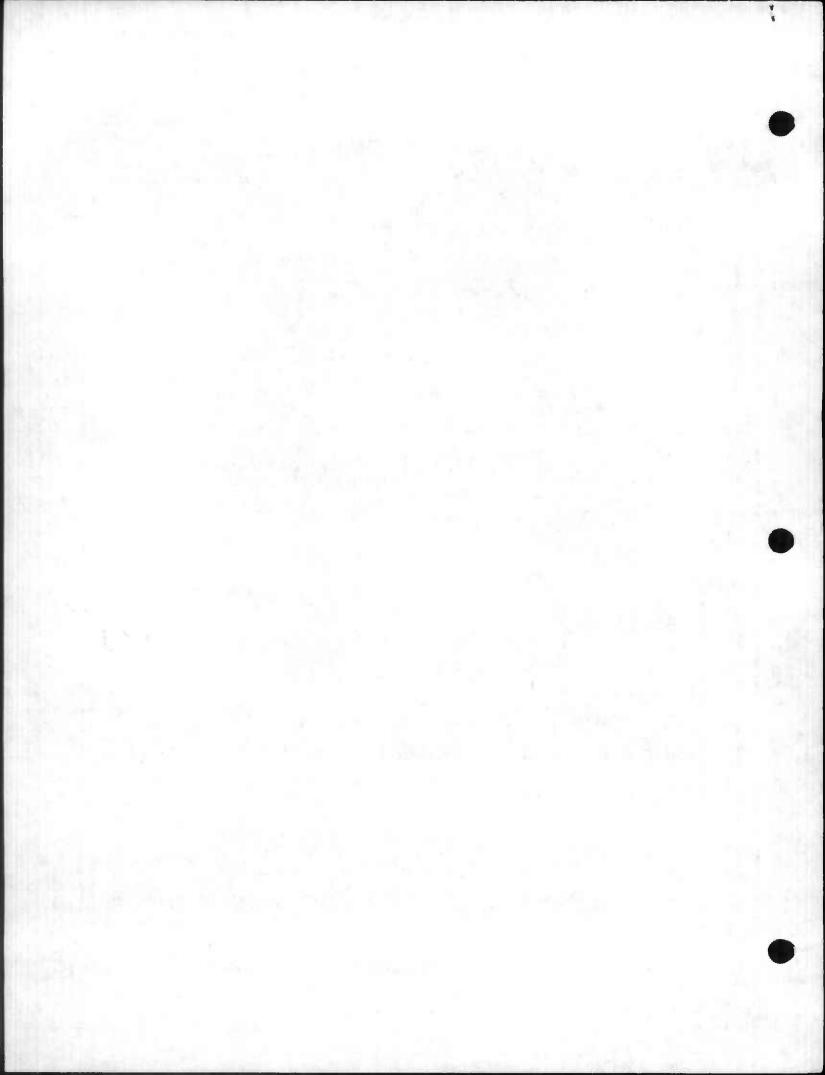
Marmen 23, 2000



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State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 2 4 9

			Cer	tificate of Death	Reg. No.	
п			1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Dey Yea	3. Time of Deeth
	Physicia Medic/		JAMES GOODMAN			200 3:20 AM
	Examin		4e Facility Neme (If not Institution, give street end number)	4b. City, Town, or Lo		eeth
4			HOWARD COUNTY GENERAL HOS	PITAL COLUI	MBIA HOW	ARIO
	Funeral		Social Security Number     6. Sex	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Dey, Year)	Birthplece (State or Foreign Sountry)
	Director		263-00-9163 10M 20F 64 Yrs.	Months Deys Hours Min.	MAR 30, 1936 6	FORSIA
ь		7	Usuel Residence of Decedent		11/14/200, 106	0000
	show		10a. Sfete 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
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	with the Maryland a or 28a-f show	9	10e. Street and Number	10f. Zip Code	10g. Citizen of Whet	Country?
	th with	ā	Edga The RRIDLE ALL	2101/1/	119	A
	death w	Funeral Director	11, Menital Status / 12. Wes Decedent Ever in U.S. 13. W	/es Decedent of Hispanic Origin? (Sp	onity Ves or No. 14 Bace - A	merican Indien,
		S	Armed Forces?	Yes, specify Cuban, Mexicen, Puerto	Rican, etc.) Black, W	/hite, etc.
20	8 8	by F	1  Never Merried 2  Married 1  Mes 2  No If fes, Give 1 3  Widowed 4  Divorced Yeer or Detes:	☐ Yes 2 PNo Specify:	Specify:	SlARA
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	net net	lete	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation <i>rind of work done during most of work</i> O NOT use ratired)	ing 16b. Kind of Busine	essindustry
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and	od sta	Be	17. Father's Neme (First, Middle, Last)	M A	e (Filst, Middle, Maldell Surrelle)	
K	should be filed vind Mental Hygie marked other I	10	JAMES DEVATA GOODINAN	1111900	OLIA LOWI	5
Mary	0 0 0		19a. Informent's Neme/Reletionship (Type, Print)	Address (Street end Number or Run	al Route Number, City or Town, Stat	a, Zip Code) 3/044
	other tr		EdnA GOODMAN/WIGS43	9 The DRIGIE	PATA (alhr	DIA Md
ore	ges 1 f of H ff her or off		20e. Method of Disposition  1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State	etofy or other place)	Dete 20c. Location - City	or Town, State
Baltimore	Pages nent of unt: If it uny or o		4 Donetion 5 Other (Specify)	TI-RANG (FM )	2/4/2000 CRim	sville md
alt	permit. Pag Department important: any Injury ang Enga.		21. Signature of Funerel Service Licensee 22:	Name and Address of Facility	JONES TR	FHPA
B	Depa impo any l		More adam ones	INCS/IN I	1 Roll	md 21229
			23e. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter	the mode of dving, such as cardiac	or respiretory errest.	Approximate
	Discordadas		shock, or heert failure. List only one cause on each ne.			Intervel Between Onsat end Death
9	Physician /Medical		Immediate Cause (Final	sho ck		1 - 0
4	Examiner		resulting in death) a.			quys
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9			cause. Enter Underlying Cause (Disease or injury c.			
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of Vital	\$ 000	2	examiner?  1 Yes 2 PNG Hospitel: Topatiant 2 ER/Outpatient	3□ DOA Other: 4□ Nursing Ho	oma 5 Rasidence 8 Other (5	Specify)
	er th		27. Manner of Death 28a. Deta of Injury (Month, Dey Year)  1≥Statural 5 □ Pending (Month, Dey Year)	28c. Injury et Work?	28d. Describe how Injury occurred	
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Vis	Atte	Fig	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be datarmined  28e. Plece of Injury - At home, tarm, stree building, atc. (Specify)	et, factory, office	28f. Location (Street and Number o City or Town, Stete)	r Rural Route Number,
ā	a after d	Certification:	4 ☐ Homicide building, atc. (Specify)		Only of TOWN, Stoley	
	To the Hospital or Attending Physical Design 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.		29a. Certifiar Certifying Physician: To the best of my knowledge, deeth	occurred at the time, date and plece,	end due to tha causa(s) and manne	or es steted.
	Ho Fu Fu	edical	(Check only 2 Medical Examinar: On the basis of examination end/or invene) end menner steted.	stigation, in my opinion, deeth occur	red et the time, date and place, and	due to the cause(s)
	400	Me	29b. Signeture end fitte of certifier	29c. License number	29d. Date signed (M	Ionth, Dey, Year)
	101		ND un, fcc	D36845	Na. 2	5.2000
	11		20 Name and address of pages who consists of the Constitution of t		JGUYEN, MO	
,	201		30. Name and eddress of person who completed cause of death (Item 23a) (Type, F	* . 0 0 1	THE PROPERTY.	, , , ,
	V		31. Dete filed (Month, Dey, Year) 32. Ragistrer's Signeture	3, 191) 2/00	+4	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** FRANCES GREER 1:45001 NOVEMBER 24,00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOUR BALTIMORE 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. 8. Dete of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Sociel Security Number 6. Sex **Funeral** 1□M 20 F 219-18-7385 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21 Name 23a tarm Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Merried 2 ☐ Married "natural", or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify à 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) er 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be and Mental is marked Simon 19a. Informant's Name/Reletionship (Type, Print) (daughter, 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Health Hem 27 Mar lene 20b. Plece of Disposition (Name of cemetery, cremetory or other) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If the 1 Burial 2 Cremation 3 Removat from State 4 ☐ Donation 5 ☐ Other (Specify) ationa 21. Signature of Funerel Service Louis 22. Name and Address of Facility Hor Joseph er W. North 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es e consequence of): ettending physician Box 68760. Due to (or as a consequence of): the 98 P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: 25. Was case referred to medicat 26. Plece of Deeth (Check only one) Hospitat: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Hospital 1 ☑ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and ptace, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier NOVEDBER, 24, 043462 C.S. RAO. M.D

State

Registrar

MORTHWEST HOS

31 Date flied (Month, Day, Year)

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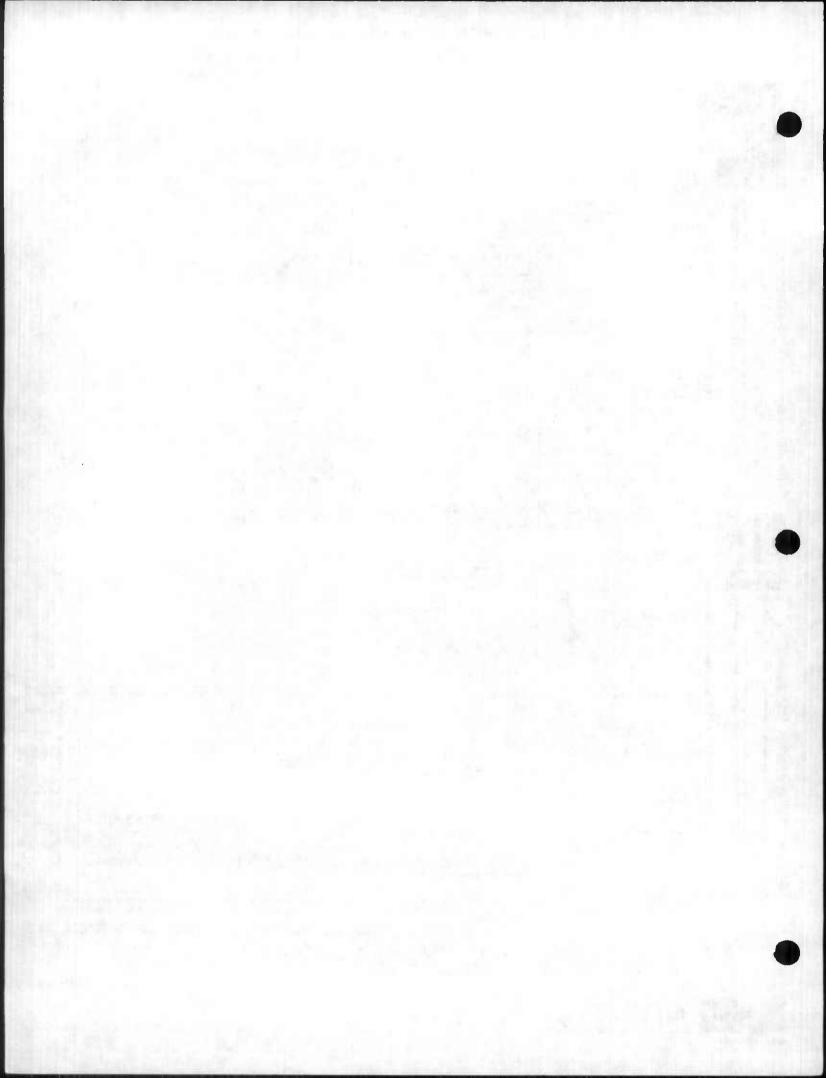
ENTER RANDALLSTOWN

30. Name and address of person who completed cause of death (tem 23a) (Type, Print) / . S . R A O . T . . O .

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PITAL

32. Registrar's Signature

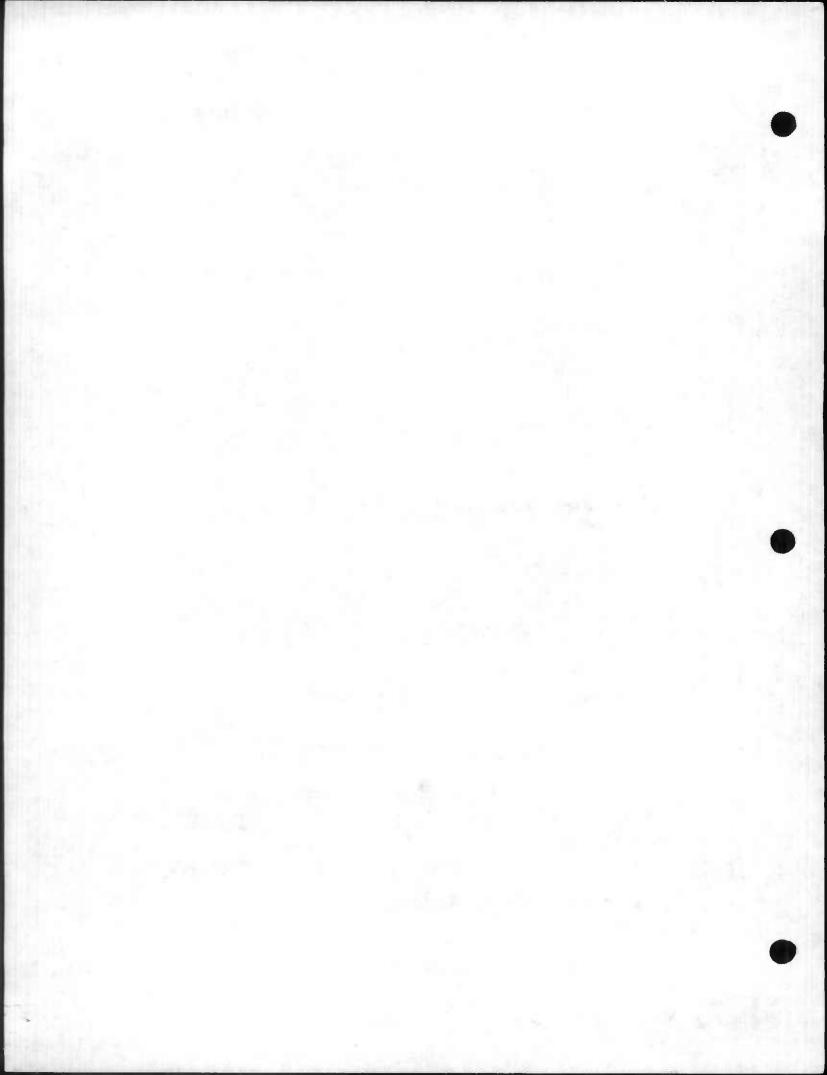


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State of Maryland / Department of Health and Mental Hygiene 00 2725

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/Medical Examiner	4a Fecility Name (If not inst							4b. City, Town, or	The second second	7	ty of Deet				
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any in ance	21. Signeture of Funeral Service Licensee  22. Name and Address of Facility  Baltimore, Mary  WM.C.March FH 1101 E. North  23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest,														
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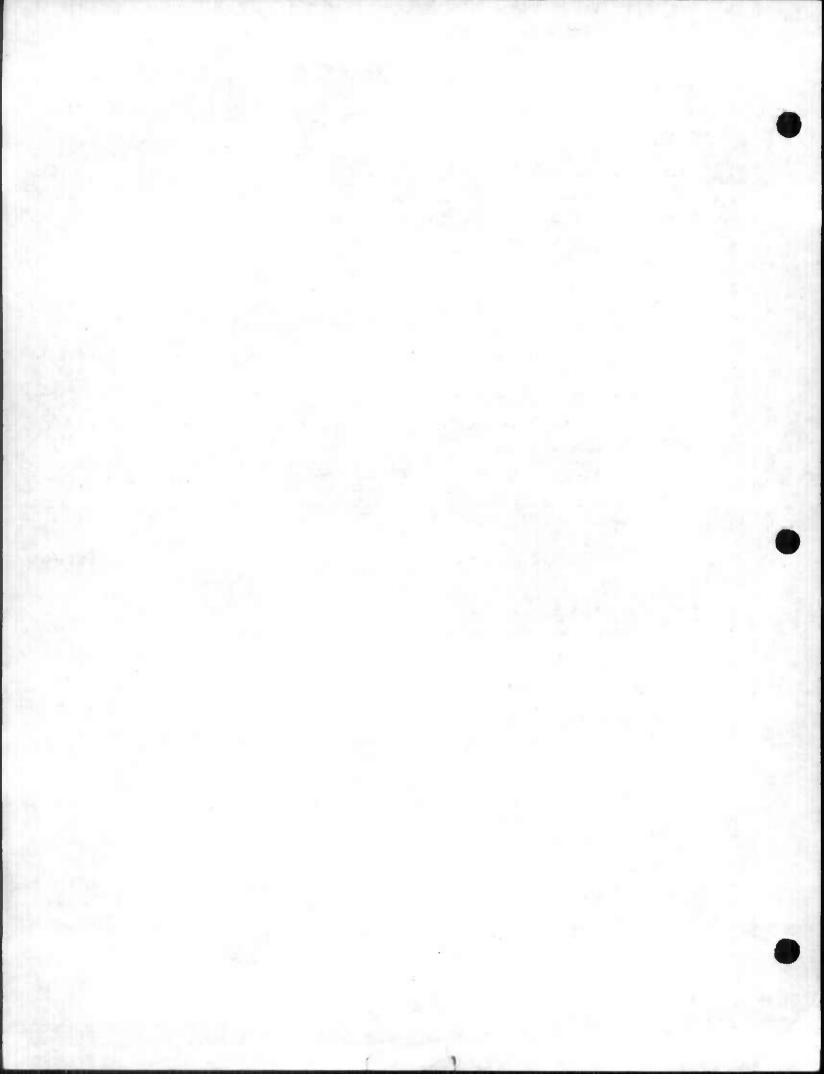
DHMH 16 Rev 6/95



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 3. Tima of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20 JEE pm 2000 EMENT 10V 18 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 1824 E. 31 ST BALTIMORG STREET Hours Min. 8. Date of Birth (Month, Day, Year) AUG 30 \QQ8 If Under 1 Yeer 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months 1XM 2□ F 92 214-01-6536 Vrs **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 Yes 2 No MP Director NA BACTIMORE 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code USA STREET 21218 1824 3157 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiena.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Marias Examina 1 Never Married 2 Married Yes 278 No Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: à BLACK 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Coast NA ONGSLOREMAN 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be INGZ GG= EANDER GEE 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. 31ST DACTO. STREET lames Capley GRandson 1824 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from Stete White Harsh Hills Hen. Gardon 100 40 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21 Signature of Funeral Service Licenses Home March Funeral Bal 21215 4300 Wabash Aue to 23a. Part. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, about, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** /Medical fmmediate Cause (Final ALHAIMANIS disease or condition resulting in death) DISKASA YEAR S Examiner Due to (or as a consequence of): Examine requires that the death certificate be executed g physicien and as the buriel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 950 for signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to completion of cause of death? been sign 24a. Was en eutopsy performed? Completed certificate has b lirector, page 2 s 2 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funerel director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -000 66 n. Man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3333 CALVENT STAKE DALI IMONK NORTH 31. Date filed (Month, Day, Year) NOV 2 7 2000 37. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 16 Rev 6/95



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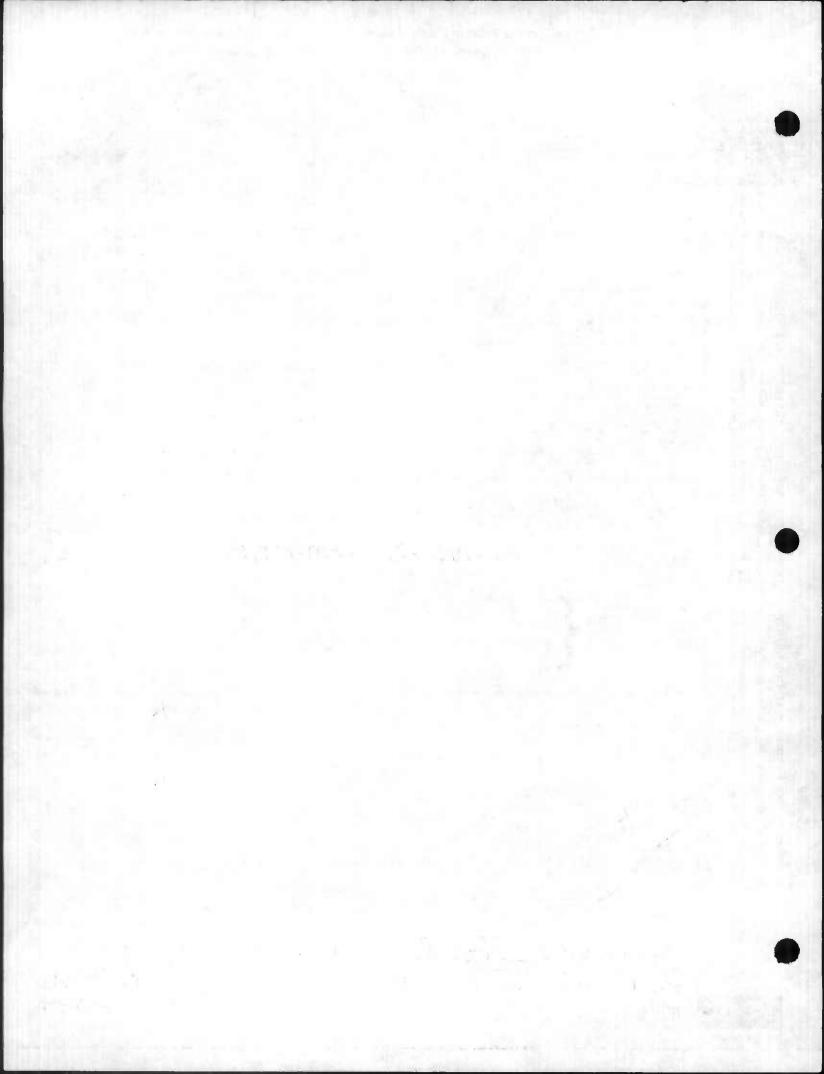
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State Registrar

NOV 2 7 2000

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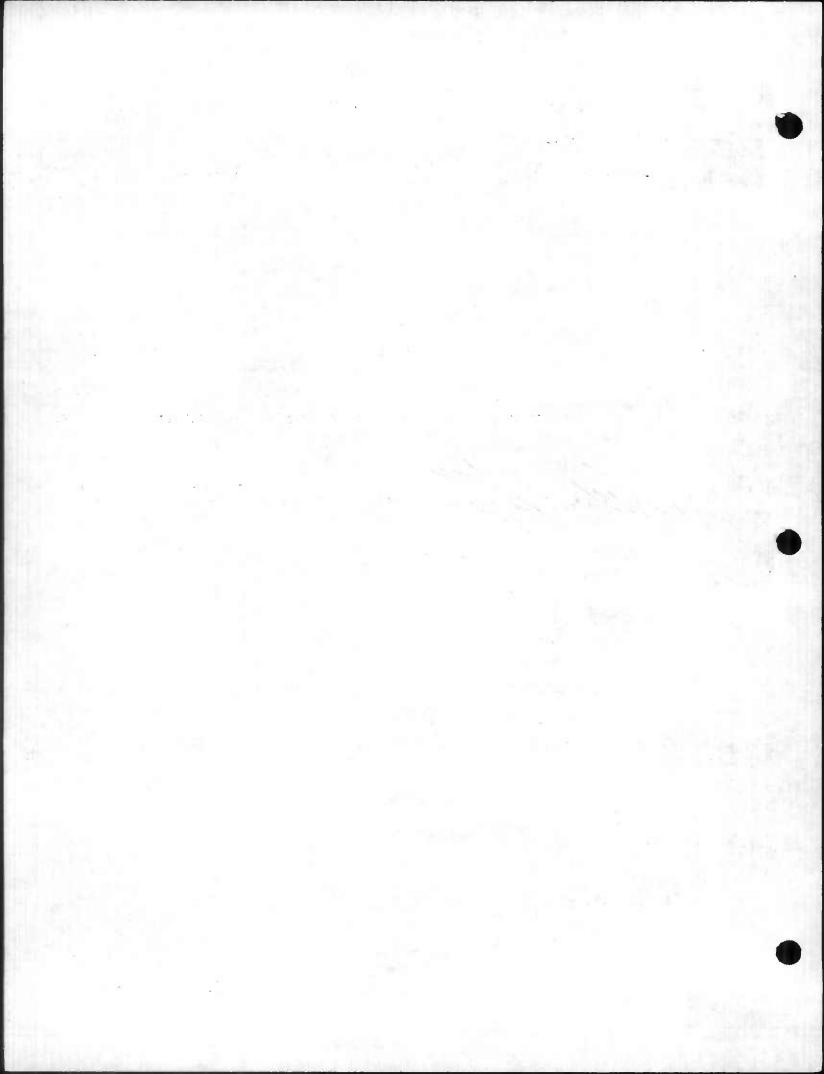


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eral tor	5. Social Security		6. Sex	M 2 F	7. Age (In yr.	s. last birthday, 86 Yrs.	Months	er 1 Year Deys	If Under 24 H Hours M		Birth Day, Y	(ear) 1914	9. Birthpl Count	lace (State or Foreign try) ENGLAN
	Usuel Residence	of Decedent 10b. Count	ly		10c. (	City, Town or L	ocation					IGA II	10	Od. Inside City Limits
ctor	MD	BAL	TIMOR	RE		LUTHER	RVILL	E						1 ☐ Yas 2 No
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by	1 Naver Me	orried 2 Me	rried	Armed For 1 Yes If Yes, Given Year or D	rces? 2 No /e	0,0.			Hispenic Origin? en, Mexican, Pu Specify:	erto Rican, etc.	) "	Specify: WHITE		etc.
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Be C	17. Father's Nem	e (First, Middle	, Last)						18. Mother's N	18. Mother's Name (First, Middle, Maiden Surname)				
2		MORRIS  GELKIN  RACHEL  19e. Intorment's Neme/Reletionship (Type, Print)  19b. Melling Address (Street end Number or Rural Route Number, City or Town, St.										NKNOWN)		
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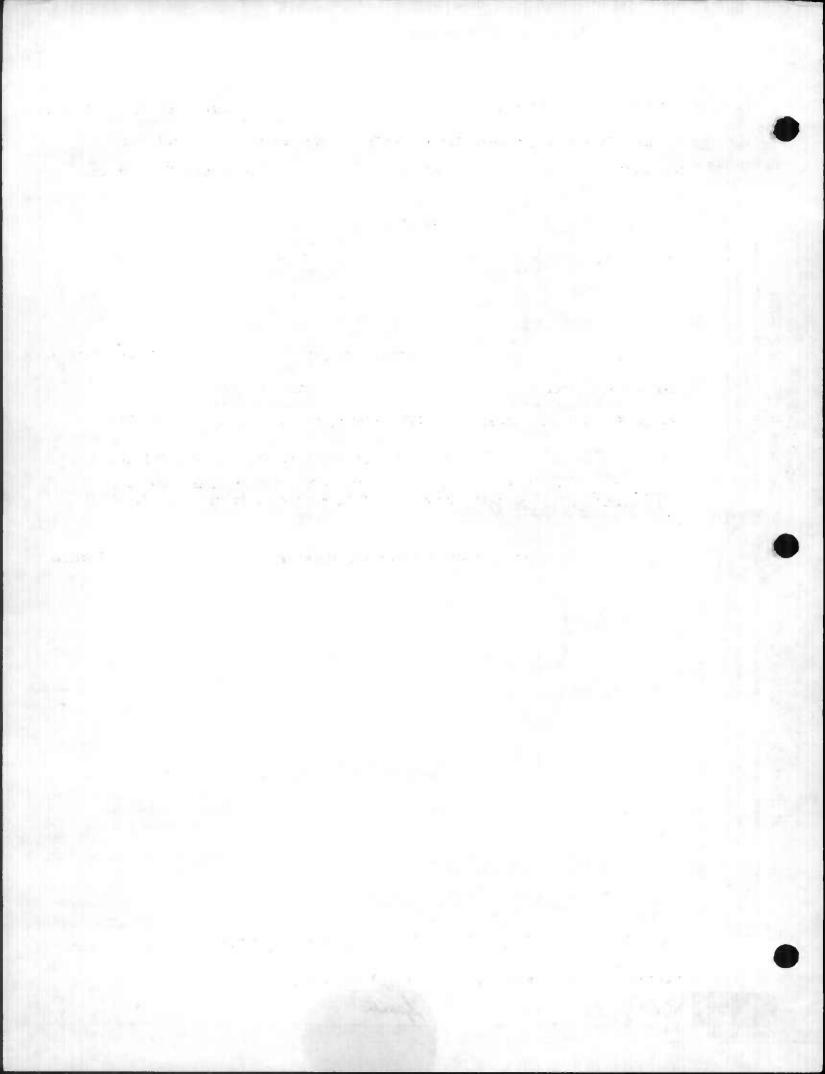


Anthony C. Hooker, Sr.  Bott Howard M McLocated Century Rart Howard Md 2062  Bott Howard  Bott Howard  Britimore  But Howard  Britimore  Diversification  Diversificatio		Decedent's Name	e (First Middle I	act)		Cel	tificate	UI L	reall!	2. Date of D	Reg. No.		3. Time of Deat
Rott Howard   VA Medical Center, Fort Howard Mil 21052   Fort Howard   Social Source   Number   Control   Social Source   Number   Control   Con		Anthony	y C.	Hooker,						Month Novembe	Day 22, 20	000	@ 8:35pm
Social Social Social Properties   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1			11-1-1-1										
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Md. n/a Baltimore	-									2			
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17.14 Montery Street  11. Marinal Status  12. Was Decedent Evar in U.S. Armed Forces?  13. Was Decedent Haspenic Origin? (Specify Yes or No. Monter)  14. Reac-Armed Indian. Black, White, etc. Specify. White  15. Decedent's Education  (Specify or In Principle Compiled)  15. Decedent's Education  (Specify or In Principle Compiled)  16. Decedent's Specify Status Occupation  (Specify or In Principle Compiled)  17. Father's Name (First, Middle, Last)  18. Monter Name (First, Middle, Last)  19. Mailing Address (Sitned and Number or Plane Route Number, City or Town, Stelle, Zp Code)  19. Mailing Address (Sitned and Number or Plane Route Number, City or Town, Stelle, Zp Code)  17. Father's Name (First, Middle, Marien Sumane)  18. Monter's Name (First, Middle, Marien Sumane)  19. Mailing Address (Sitned and Number or Plane Route Number, City or Town, Stelle, Zp Code)  17. Father's Name (First, Middle, Marien Sumane)  18. Marina Number or Plane Route Number, City or Town, Stelle, Zp Code)  19. Mailing Address (Sitned and Number or Plane Route Number, City or Town, Stelle, Zp Code)  17. Father's Name (First, Middle, Marien Sumane)  18. Marina Number or Plane Route Number, City or Town, Stelle, Zp Code)  17. Marina Number or Plane Route Number, City or Town, Stelle, Zp Code)  17. Marina Number or Plane Route Number, City or Town, Stelle, Zp Code)  17. Marina Number or Plane Route Number, City or Town, Stelle, Zp Code)  17. Marina Number or Plane Route Number, City or Town, Stelle, Zp Code)  17. Marina Number or Plane Route Number, City or Town, Stelle, Zp Code)  17. Marina Number or Plane Route Number, City or Town, Stelle, Zp Code)  18. Marina Number or Plane Route Number, City or Town, Stelle, Zp Code)  19. Mailing Address (Sitned and Number or Plane Route Number, City or Town, Stelle, Zp Code)  19. Mailing Address (Sitned and Number or Plane Route Number, City or Town, Stelle, Zp Code)	104		-		Ba	ltimo:		odo			10a Citizan of	21	
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Securities   Sec	•••		ed 2 Married	Armed Forces	s?		3.00			o Rican, etc.)			
Continue		3 D Widowed	4 Divorced	If Yes, Give Year or Dates	s:		1∐ Yes 2L	<b>X</b> No	Specify:		Speci	fy: WI	iite
Elementary/Secondery (0-12)   College (1-4or 5+)   Grounds Keeper   Board of Educati		(Spec				(Give	kind of work	done du	uring most of wor	king	16b. Kind of E	Business/Ir	ndustry
17. Father's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)	1	Elementary/Secon		College (1-4o	r 5+)	life.	DO NOT use	retired)					22
Joseph G. Hooker   Margaret Kehoe   Margaret Kehoe   19a. Informent's Name/Relationship (Type, Print)   19b. Mailing Address (Street end Number or Rurel Route Number. City or Town, Stete, Zip Code)   1714   Monterry Street, Baltimore, Md. 21230   20b. Method of Disposition (Neme of Light (Specify)   20b. Place of Disposition (Neme of Camelory or Other piece)   20b. Dete   20c. Location - City or Town, State   4 Donation   5 Other (Specify)   20b. Place of Disposition (Neme of Camelory or Other piece)   27 Symmatry of Park   27 Symmatry of Specific Place   27 Symmatry of Symmatry of Specific Place   27 Symmatry of	17.		(First, Middle, I a			Gro	unas K	-		ne (First, Middle			education
19b. Mailing Address (Sireet end Number or Rurel Route Number. City or Town, Stete, Zip Code) 1714 Monterry Street, Baltimore, Md. 21230 20b. Method of Disposition (Neme or Survey of Designation 3   Removal from State   10 Designation 3   Removal from State   10 Designation 5   Other (Specify)   21. Signature of Funeral Service Licensee   22. Signature of Funeral Service Licensee   23. Signature of Funeral Service Licensee   24. Donation 5   Other fineral Service Licensee   25. Signature of Funeral Service Licensee   26. Signature of Funeral Service Licensee   27. Month State   28. Signature of Funeral Service Licensee   28. Signature of Funeral Service Licensee   29. Signature of Funeral Service Licensee   20. Date of Original Service Licensee   21. Signature of Funeral Service Licensee   22. Signature of Funeral Service Licensee   23. Signature of Funeral Service Licensee   24. Donation 5   Other field of Service Licensee   25. Signature of Funeral Service Licensee   26. Donation 5   Other field of Service Licensee   27. Months Service Licensee   28. Port Ave. Baltimore, Md. 21230   29. Donation 6 disease or condition   29. Universal Service Licensee   29. Donation 6 disease or condition   29. Donation 7 disease or fully   29. Donation 8 disease or condition   29. Donation 9 disease or fully   29. Donation 9 di													
20b. Method of Disposition 1 Gibrial 2 Oceanion 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme et al. Donator of the place) 1 Corraine Park Cemetery 11/27/2000 Baltimore, Md. 21. Signature of Funeral Service Licenses 22 Name and Address of Eacility. MCUL1y-Polymiak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230 23b. Plat. Enter the disease, or complishions tight caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line.  Immediate Ceuse (Finel disease or condition resulting in death)  Bue to (or as a consequence of):  Due to (or as a c	_	-				19b. Mailir	ng Address (S	Street e				n, Stete, Zi	ip Code)
Sequentially list conditions are conficient southing in death) Last   Due to (or as a consequence of):    Sequentially list conditions contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contribute to the ceuse of contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contribute to the ceuse of contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contribute to the ceuse of contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contribute to the ceuse of contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contribute to the ceuse of contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contribute to the ceuse of contributing to the contribution of contributing to deeth but not resulting in the underlying cause given in Part I.   Other significant conditions contribute to the ceuse of cont	C	connie S	. Reed	(Daughter	aughter) 1714 Montery Stre					Baltimo	ore, Md.	2123	30
Lorraine Park Cemetery 11/27/2000 Baltimore, Md.	20a. Method of Disposition				emoval from State cemetery, cremetory or other place)					Dete	20c. Location	- City or T	own, State
232 Part Enter the disease, or complipations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only offe caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only offe caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only offe caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Such as cardiac or respiratory arrest, shock or					0					/27/200	0 Balti	more,	Md.
130 E. Fort Ave. Baltimore, Md. 21230	21	Signature of Fur	neral Service Lic	ensee )	/	22	Name and	Address	of Eacility	Funera	1 Home	P.A.	
Interval Bev Conset and Conset an		mu	box	Druss	whe	/	130 E	. Fo	ort Ave.	Baltin	nore, Md		230
Immediate Ceuse (Finel disease or condition resulting in death)  a. Uninary Bladler Carcinome with Metastases  Due to (or as a consequence of):  Due to (or es a consequence of)	23	Part1. Enter the shock, or hear	ne disease, or contra failure. List on	mplications that caus ly one cause on each	ed the death	. Do not ent	er the mode of	of dying	, such as cardiac	or respiratory	arrest,	1	Approximate Interval Between
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if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Dua to (or as a consaquance of):  Dua to (or as a consaquance of):    Dua to (or as a consaquance of):	0.			b	Due to (or	95 9 000000	monca of).					i	
Cause (Disease or Injury that initiated events resulting in death) Last  Dua to (or as a consequence of):  d	if a	quentially list con iny, leading to im- use. Enter Unda	imediate		00 00 00	es a consec	delica orj.						
Part II. Other significent conditions contributing to deeth but not resulting in the undaritying cause given in Part I.  23b. Did tobecco use contribute to the ceuse of the completion of conditions contributed to the ceuse of the completion of conditions	Cause (Disease or injury			C	Dua to (or	as a consag	uance of):						
24e. Was an autopsy performed?  24b. Were eutopsy first available prior to completion of confidents?  1   Yes   2   No   1   Yes   No   No   No   No   No   No   No   N							Dua to (or as a consaquance of):					1	
24e. Was an autopsy performed?  24b. Were eutopsy fi available prior to completion of confidents?  1	Ca	oung ar douting a		d									
24e. Was an autopsy performed?  24e. Was an autopsy performed?  24b. Were eutopsy fixevailable prior to completion of cold death?  1	Ca	and a same	-	d						a sizes in Red 1 29h Did tohees			A - Ab
25. Was case referred to medical examiner?  1	Ca tha res		cent conditions	d	but not resu	iting In the u	ndarlying cau	se give	n in Part I.	23b. Did	d tobecco use c	ontribute	to the ceuse of dea
25. Was case referred to medical examiner?  1   Yes   2   No   1   Yes    Ca tha res		cent conditions	d	but not resu	ilting In the u	ndarlying cau	se give	n in Part I.					
25. Was case referred to medical examiner?  1	Catha		Icent conditions	d	but not resu	Iting In the u	ndarlying cau	se give	n in Part I.	1 [ 24e. Wa	Yes 2 No	3 □ Pro	obably 41 Unkn
25. Was case referred to medical examiner?  1	Ca tha res		Icent conditions	d	but not resu	Iting In the u	ndarlying cau	se give	n in Part I.	1 [ 24e. Wa	Yes 2 No	3 🗆 Pro	Vere eutopsy finding vailable prior to completion of cause
examiner?    Yes   2X   No	Catha		icent conditions	d	but not resu	ilting In the u	nderlying cau	se give	n in Part I.	1 C 24e. Wa	Yes 2□ No s an autopsy formed?	3 Pro	Vere eutopsy finding vailable prior to completion of cause if death?
27. Manner of Death 1	Par	t II. Other signifi		d	but not resu	lting In the u	ndarlying cau	ise give		24e. Wa per	yes 2□ No s an autopsy formed?	3 Pro	Vere eutopsy finding vailable prior to completion of cause if death?
2 Accident 3 Sulcide 4 Homicide  28a. Place of Injury - At home, farm, streat, factory, office 28b. Location (Streat and Number or Rurel Route Num. Stete)  28c. Certifier  29c. Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.	Par	til. Other signifi Was case relementations	red to medical	Hospital:				Othe	26. Place of Dear	24e. Wa per	yes 2□ No s an autopsy formed?  Yes 2☒ No one)	3 Pro	Vere eutopsy finding vailable prior to completion of cause f death?
4 Homicide  determined  28a. Place of mythy - At home, streat, factory, office  building, etc. (Specify)  29a. Certiflier  29a. Certiflier  City or Town, Stete)  29a. Certiflier  City or Town, Stete)	Par Par 25.	Was case relerrexaminer?  1 □ Yes 22 □  Manner of Death	red to medical No	Hospital: 1 🔀 Inpa	tient 2□ E	ER/Outpatier 28b. Tima o	nt 3□ DOA	Othe	26. Plece of Dea	24e. Wa per 1 Lath (Check only ome 5 🗆 Res	s an autopsy formed?  Yes 2 No  Yes 2 No  one)	3 Pro	Vere eutopsy finding vailable prior to completion of cause f death?
	Par Par 25.	Was case relerrexaminer?  1 □ Yes 2 1 □ Manner ol Death  1 □ Xnetural  2 □ Accident	red to medical No h 5 ☐ Pending investigati	Hospital: 1 X inpa  28a. Date of ir (Month, L	tient 2□ E	ER/Outpatier 28b. Tima o	nt 3□ DOA	Othe	26. Plece of Dear. r: 4□ Nursing H	24e. Wa per 1 Lath (Check only ome 5 🗆 Res	s an autopsy formed?  Yes 2 No  Yes 2 No  one)	3 Pro	Vere eutopsy finding vailable prior to completion of cause if death?  Yes 2 No
(Check only 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s	Par 25.	Was case referrexaminer?    Yes 27   Manner of Death   The Netural   Netural   Succident   Sulcide	red to medical  No  h  5	Hospital: 1 🔀 Inpa  28a. Date of Ir (Month, L	itient 2 🗆 B	ER/Outpatier 28b. Tima o Injury	nt 3□ DOA 28c	Othe Dilury Work 1 Y	26. Plece of Dear. r: 4□ Nursing H	24e. Wa per 1 Check only ome 5 Rec 28d. Describe	yes 2□ No s an autopsy formed?  Yes 2☒ No r one) sidenca 6 □ Ot s how injury occur (Straat and Num	3 Pro	Vere eutopsy finding vailable prior to completion of cause if death?  Yes 2 No
29b. Signature and titleyof certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)	Pari 25.	Was case relerrexaminer?  1 Yes 2 1 2 Accident 3 Suicide 4 Homicide  a. Certifier (Check only)	red to medical  No  h 5   Pending investigati 6   Could not determine	Hospital: 1 X Inpa  28a. Date of Ir (Month, L)  28a. Place of Ir building,  Physicien: To the bes	itient 2 I ijury Jey Year) Injury - At horetc. (Specify,	ER/Outpatier 28b. Tima o Injury ma, farm, str )	aat, factory, c	Othe  Injury Work  1  Y  office	26. Plece of Dear  T 4 □ Nursing H  at  7  as 2 □ No	24e. Wa per 1 Check only ome 5 Rec 28d. Describe 28f. Location City or 7d.	Yes 2□ No s an autopsy formed?  Yes 2☒ No r one) sidenca 6□Ot how injury occu (Straat and Num own, Stete) a cause(s) and m	3 Pro 24b. V a c o 1 ther (Specurred	Vere eutopsy finding valiable prior to completion of cause if death?  Yes 2 No  Prel Route Number, stated.
Jelu q. Chima. 34359 (0410) 1/22 2000	Par Par 25.	Was case reterrexaminer?  1 Yes 2X   Manner ol Death 1 XNetural 2 Accident 3 Sulcide 4 Homicide a. Certifier (Check only one)	red to medical  No  h 5	Hospital: 1 X inpa 28a. Date of Ir (Month, L) ion be d 28a. Place of building, Physicien: To the bes	itient 2 I ijury Jey Year) Injury - At horetc. (Specify,	ER/Outpatier 28b. Tima o Injury ma, farm, str )	aat, factory, c	Othe Injury Work 1  Y office the time	26. Plece of Dear.  r: 4 Nursing H at ? fas 2 No e, dete and place inion, deeth occur	24e. Wa per 1 Lath (Check only ome 5 Rec 28d. Describe 28f. Location City or 7d. , and due to the rired at the time	S an autopsy formed?  Yes 2 No  Yes 2 No  One)  Sidenca 6 One Show injury occur  (Streat and Num own, Stete)  e cause(s) and me, date end place	3 Pro 24b. V 8 8 6 0 1 1 ther (Specured	Vere eutopsy finding vailable prior to completion of cause if death?  Yes 2 No  rel Route Number,  stated. to the ceuse(s)

State Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year) NOV 2 7 2000

32. Registrar's Signeture



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State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 2 5 6

			Certificate	of Death	Re	g. No.		
	1. Decedent's Neme (First, Middle, Last)				2. Dete of Death Month	Dev	3. Tima of Death	
Physician /Medical	Philip		Hur	d_	November	01 00	000 21:15	
Examiner	4e Facility Neme (II not institution, give s	treet and number)		4b. City, Town, or	Location of Death	4c. County	of Deeth	
	The Johns Hopki	ins Hospital		Baltimore				
eral	5. Social Security Number 6. Sex	7. Age (In yrs. last	Months D	eer If Under 24 Hrs. eys Hours Min.	8. Dete of Birth (Month, Dey,	Year)	9. Birthplace (Stete or Foreig	
or	216 34 1221	600	Yrs.		May 30,	1938	Maryland	
	Usual Residence of Decedent  10a. Stete 10b. County	10c. City. T	own or Location				10d. Inside City Limits	
5	man had nula	7	HMORE				1 ☐ Yes 2 ☐ No	
Directo	10e. Street end Number	De	101. Zip Co	de	10	g. Citizen of W	/hat Country?	
	- 1 A			1216		11. S. A.		
era era	3400 Elgin Aver	2. Wes Decedent Ever in U,S.			pacify Yas or No-	14. Race	- American Indian,	
Funeral	1 Never Merried 2 Merried	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify	of Hispanic Origin? (S Cuben, Mexican, Puer	o Rican, etc.)		k, White, etc.	
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:	1 ☐ Yes 2 🎢	No Specify:		Specify:	Block	
	15. Decedent's Educ	ation 1	6e. Decedent's Usuel O	ccupation	. 1	6b. Kind of Bu	siness/industry	
Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work d	one during most of wo stired)	rking			
mo.	Elementary/Secondary (U-12)	2	Media To	echnician		Comn	nunication	
0 9	17. Fether's Neme (First, Middle, Last)			18. Mother's Ner	ne (First, Middle, M	le <i>ide</i> n Sumam	e)	
To Be	William Joseph	Hurd SR		Ida (	coles			
-	19e. Informent's Neme/Reletionship (Typ	e, Print)	19b. Meiling Address (Si	reet end Number or Ri	ral Route Number,	City or Town,	Stete, Zip Code)	
	Daphne La Verne H	wed/Wife 3	3400 ElgiNH	I Venue Be	altimore	Maky	land 21216	
	20e. Method of Disposition	cem	e of Disposition (Neme of etery, cremetory or other	of place)	Dete 2	Oc. Location -	City or Town, Stete	
	1  Burial 2  Cremetion 3  Re 4  Donetion 5  Other (Specify)	emovel from State	AAA . /	1RK	11/28 pm 7	Willimore	County Moreyal	
8	21. Signeture of Funeral Service Lights		22. Name and A	ddress of Fecility //			e Helison	
8	Manah 40	1/2000	100 11.	TAN 5340 F	1 1 1	WN BO	ad )	
	23e. Pert1. Enter the disease, or complic shock, or the rt failure. List only one	ations that caused the death.		dving, such es carde		<u>オ/う</u> st,	Approximete	
an	shock, or halirt failure. List only one	e cause on eech line.					Onset end Deeth	
al	Immediate Cause (Final	Massive In	tracerebral	Hemorrhag	e		7 Days	
er	disease or condition resulting in deeth)							
ě 🖺		Hypertensi	s e consequence of): .On				40 Years	
Examiner	Sequentially list conditions b.		s e consequence of):					
Ě	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury c.							
edical	that initiated events	Due to (or es	e consequence of):					
	resulting In death) Lest							
2	d.							
hysician	Pert II. Other significant conditions cont	ributing to death but not resulting	no in the underlying caus	e given in Pert I.	23b. Did to	bacco use cor	ntribute to the cause of death	
Completed by Physician/M			, , , ,		1  Ye	_	3 Probably 4 Unknow	
× ×						X		
leted by P					24e. Wes ar	autopsy	24b. Were eutopsy findings eveilable prior to	
plet					parioni	1607	completion of cause of deeth?	
E					1□ Ye	s 218 No	1 ☐ Yes 2 ☒ No	
Ве Сош	25. Wes case referred to medical			26 Place of De	eth (Check only on			
ToB	avaminar?	ospitel: 1 ☑ Inpatient 2 ☐ ER	VOutpatient 3☐ DOA	Other:	lome 5 ☐ Reside		er (Specify)	
n: To	27. Menner of Deeth	1	3b. Time of 28c.	Injury et Work?	28d. Describe ho			
otte	1 Neturel 5 Pending 2 Accident investigation	(Month, Day 19ar)	Injury M	1 Yes 2 No				
E C	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At home	e, ferm, street, fectory, o	ffice	281. Location (Str. City or Town	reet and Numb	er or Rurel Route Number,	
	4 LI Homicide	building, etc. (Specify)			Oily or Town	. 31010/		
e			dge, deeth occurred et t	he time, dete end plece	e, end due to the ca urred at the time, de	use(s) end ma ete end pleca, i	anner es stated. and due to the ceuse(s)	
lical Cert	(Check only 2 Medical Examin	er: On the basis of examinetion	and/or investigetion, in	,				
Wedical Cert	(Check only 2 Medical Examinone)	er: On the basis of examination and menner stated.			20	d. Date sinner	d (Month, Dav. Year)	
Medical Certification:	(Check only 2 Medical Examin	er: On the basis of examinetion		icense number			d (Month, Day, Year)	
Medicai Cert	(Check only 2 1 Medical Examinone)  29b. Signature and title of certifier  Let	er: On the basis of examination and menner steled.	29c. L				d (Month, Day, Year)	
Medicai Ceri	29b. Signature and title of certifier  29b. Neme and eddress of parson who core	er: On the basis of examination and menner steled.	29c. L J 3e) (Type, Print)	S6133	N	ovember	23, 2000	
Medical Certifi	(Check only 2 1 Medical Examinone)  29b. Signature and title of certifier  Let	er: On the basis of examination and menner steled.	29c. L D 30) (Type, Print) th Wolfe St:	S6133	N	ovember	23, 2000	

DHMH 16 Rev 6/95

ORIGINAL

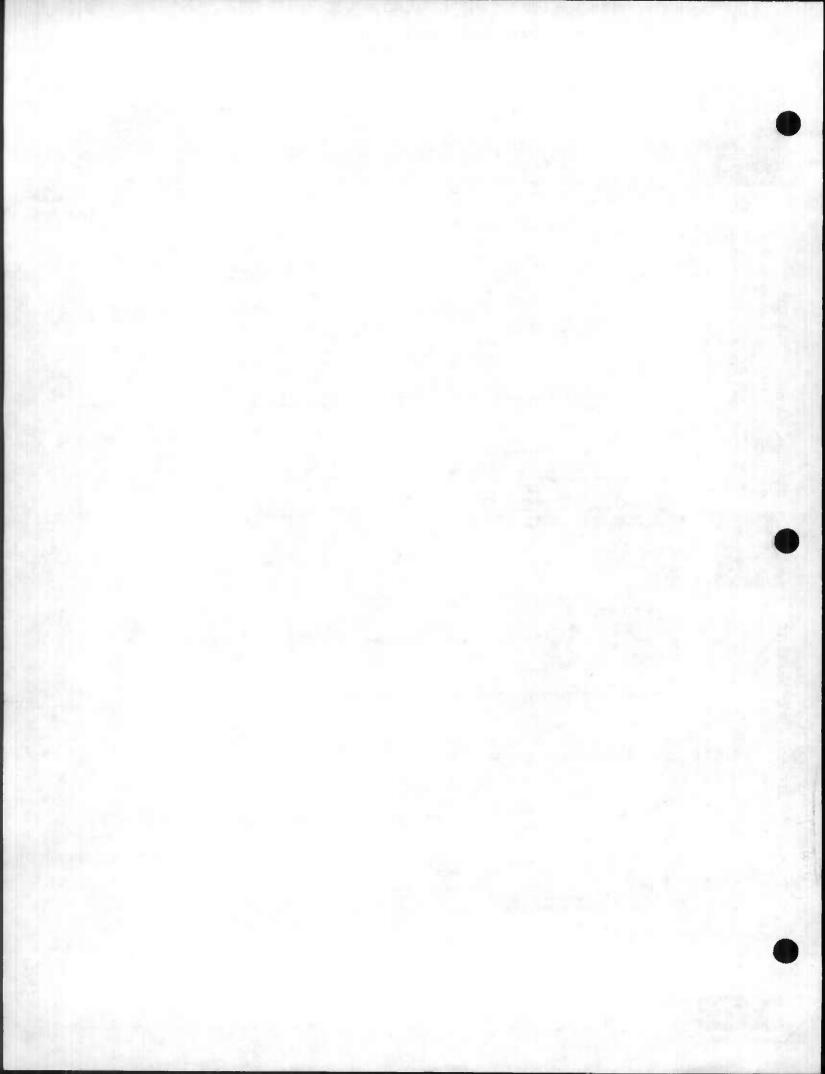
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	State of Maryland / Department of Health and Maryland / Certificate of Death	vieritai mygie Reg	00	3/25/
	Decedent's Name (First, Middla, Last)	2. Data of Death Month	Day Year	3. Tima of Death
Physician /Medical	IRVIN LEE HOLCOMBE		22 200	0 1:30 AM
Examiner	4a Facility Nama (If not institution, give street and number)  4b. City, Town, or L	ocation of Death	4c. County of Deat	h
	LORIEN NURSING HOME (FRANKFORD) BATTMO	RE	N	A
Funeral Director	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) ft Under 1 Year It Under 24 Hrs. Yrs. Months Days Hours Min.	8. Data of Birth (Month, Day Y	ear) Go	thplace (Stata or Foreign
Director	Usual Residence of Decedant	01-12-192		1110
in in	10e. State 10b. County 10c. City, Town or Location			10d. inside City Limits 1 ☑ Yas 2 ☐ No
must be notified at must be notified at heral Director	MO N/A BALTIMORE			
Dire	10e. Streef and Number 10f. Zip Coda	109	. Citizan of What Co	ountry?
oral pra	11. Marifal Status 12. Was Decadant Eyer in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	pacify Yes or No.	14. Race - Ama	Alcan Indian
iner must	Armed Forces? If Yas, specify Cuban, Maxican, Puerto	Rican, atc.)	Black, Whit	
by	M.V. Ola		Specify: B)	ACK.
pet	15. Decedent's Education  16a. Decedent's Usual Occupation  (Case kind of word done during most of word	king 16	b. Kind of Businass	Industry
Completed	(Specify only highest grade completed)  (Giva kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)		00	20
So	LITH GRADE NIA ASSEMBLY WORKER		CONTRAC	IUK
98	Lanca de característicos de cara	ne (First, Middla, Ma	idan Sumame)	
2	19a. Informant's Name/Relationship (Type, Pript)  19b. Mailing Addrass (Street and Number or Ru	ral Boute Number (	city or Town State	Zin Code)
	AUFN HOLCOMBE SON 5304 TODD AVE. B	ALTO, MI	21201	
	20a. Method of Disposition  20b. Place of Disposition (Nama of cemetery, crematory or other pleca)		c. Location - City or	Town, Stata
	1 W Burial 2 I Cramation 3 I Removal from State	11-27-00 BA	4170. MD	
injury Se	CO Alice of Address of Calling			105
28	22. Nama and Address of Facility VAUGHN C. GREENE 5,5151 BALTO, NATL. PI	KE BAL	D- MO.	21229
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or herm failure. List only one cause on each line.	or raspiratory arras	0-110-	Approximate interval Batween
cian				Onset and Death
dical liner	Immediata Causa (Final disaasa or condition Dewent			5 yrs
	resulting in death)  Dua to (or as a consequence of):			1
Examiner	b			l
burial-transit al Examir	Sequentially list conditions, if any, laeding to immadiate cause. Enter Underlying Cause, (Disease or injury c			
the buria	thet initiated evants Due to (or as a consequence of).			
use as the	resulting In death) Last			
d by the attending pletached for use as introduced for use as introduced by sician/Mex	d			
hed f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld tobe	scco use contribute	e to the cause of death?
detached		1 Yes	2 2No 3□P	robably 4 Unknown
£ 2 5		24a. Was an	autopsy 24b.	Wara autopsy findings
mpleted		performe	d?	available prior to complation of cause of daath?
page 2 should		1 ☐ Yas	2 XNo	1 🗆 Yas 2 🕅
e C	25. Was casa rafarred to medical 26. Place of Dee	oth (Check only one)	2/4/10	2,040
	exeminar?	loma 5 ☐ Rasidan	ce 6 □Other (Spe	ecify)
70	27. Manner of Death 28a. Data of Injury 28b. Time of 28c. Injury at	28d. Dascribe how	injury occurred	
he funer	2 Accident invastigation M 1 Yas 2 No			
ed in by the funera	3 ☐ Suicida 6 ☐ Could not be determined 28e. Place of Injury - At homa, farm, straat, fectory, office building, atc. (Specify)	281. Location (Stre City or Town,		Rural Routa Number,
Medical Cert	29a. Cartifiar (Check only 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occur			
) N	one) and mennar stated.  29b. Signature and fitta of certifier 29c. Licanse number	290	I. Data signad (Mon	th, Day, Year)
3/	Marshaul V. Martack. DUETE			
X	20 Name and address of person who completed are ad death (from 22a) (Time Act)	/ /	U	P. I - MD
1	30. Name and address of person who completed causa of death (Item 23a) (Type Print)  MARNAL M(NABAG 5565 / Hopkins B.	the view	Circle	BAIT MI) 21224
State	31. Data filed (Month, Day, Year) 32. Registrar's Signature	7		0.0-1
egistrar	NOV 2 7 2000 Denever la long of			
6 Rev 6/95	The property			

ORIGINAL

IRVIN HOLLOMBE



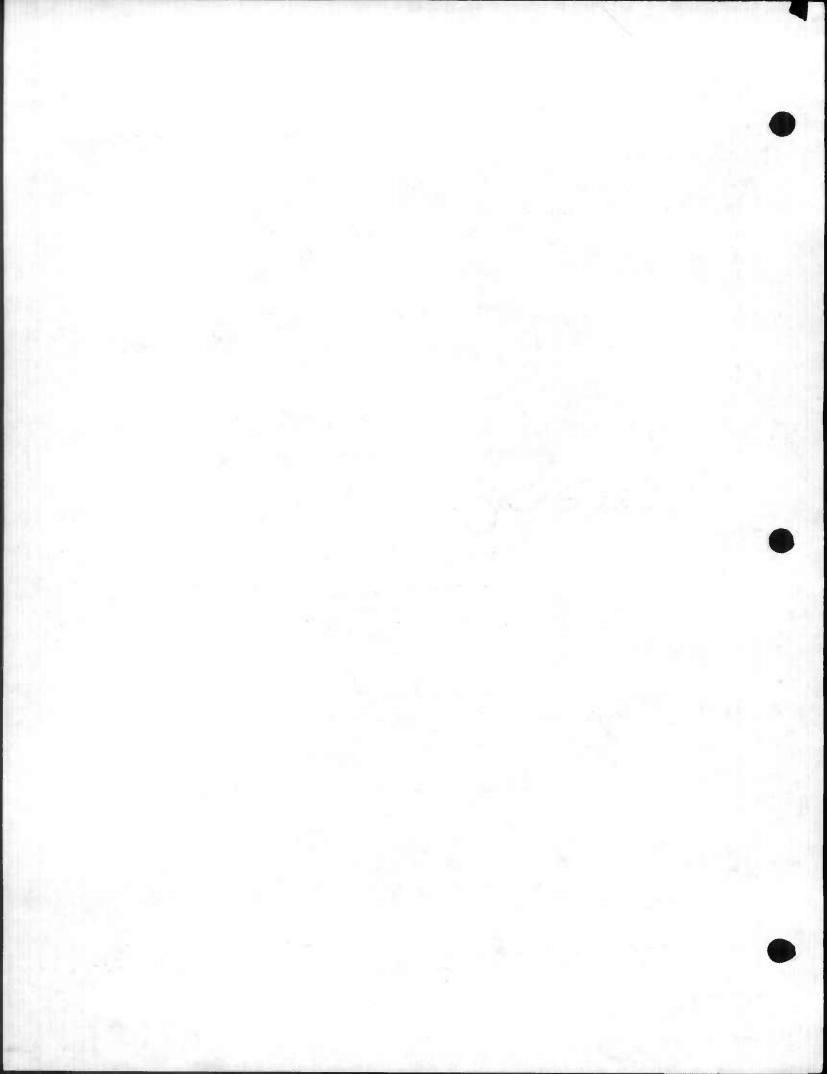
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State of Maryland / Department of Health and Mental Hygiene | |

Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month NOV **Physician** 1125 am 41665 HEZEN /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner COLUMBIA HOWARD COUNTY GENERAL HOSPITAL HOWAKD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M -2 F 132-18-9309 75 Director August 14, 1925 NY Usual Residence of Decedent 10b. County Putnam 10a. State NY 10c. City, Town or Location 10d. Inside City Limits Cold Spring 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 dical Examiner must be 6 Church Street. 10516 'natural', or flams 23s. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Country Club Office Manager 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be should be ind Mental is marked Joseph Grevich Anna Camobell 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iit. Pages 1 and 2 si arment of Health an etant: if hem 27 is n Ronald Higgs / Son 10427 Wetherburn Road, Woodstock Maryland 21163 Saltimore, 20b. Placa of Disposition (Name of camatary, cramatory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removel from Stata 4 Donation 5 Other (Specify) Cold Spring Cemetery November 29, 2000 Cold Spring, NY 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Addrass of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CONGESTIVE HEART FAILURE 400M.S Examiner Due to (or as a consequence of) CORONARY AKTERY Examine Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last attending physician for use as the buria HYPER CHOLESTEROLEMIN YEARS 68760 Physician/Medical Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown BRONEHOGENIC CARCINONIA Records. PV 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vitai 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 0 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Watural 5 Panding Investigation death. 1 Yes 2 No 2 Accident or Attendation of the order 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated. edicai 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 268240 median NOV 25 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA LITTLE PATURENT PAKKWAY FRANCIS CHUIDIAN 10724 MD ZIEYU NOV 2 7 2000 32. Registrar's Signature State Registrar Goods!

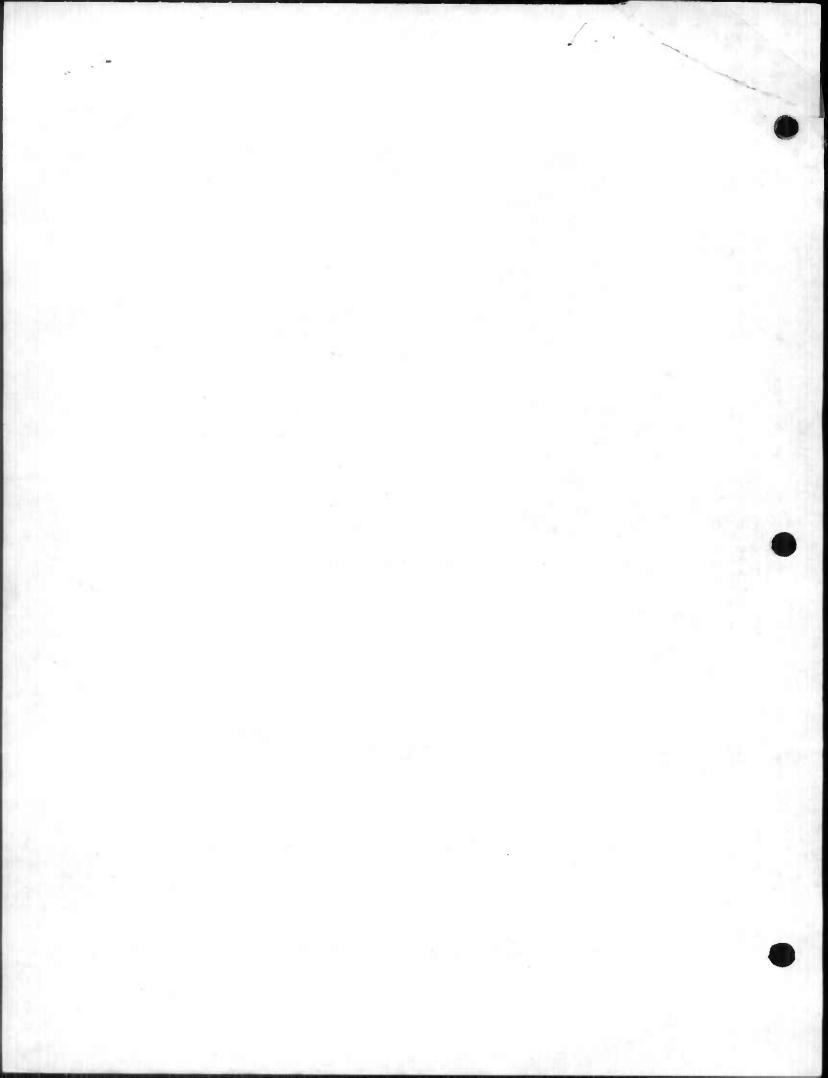


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State of Maryland / Department of Health and Mental Hygiene

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Medical Axaminer 4	1. Decedent's Name (First, Middle Michael Aaro le Facility Name (If not institution SHOCK TRAUMA	n Hunt						Month	Dey	Yeer		
aminer 4	le Facility Name (If not institutio		Michael Aaron Hunt								2:54 A.M.	
or L	SHOCK TRAUMA	i, give street and n	um <i>ber</i> )		-	4	b. City, Town, or Lo	NOVEMB ocation of Deeth			2:54 A.M.	
tor	OLIOCK TIMIOLEI						BALTIMOR	RE.	N/A	1		
U 1	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthdey)	If Under 1		If Under 24 Hrs.	8. Date of Birth (Month, De)	1		(Stete or Foreign	
1	UNKNOWN Usuel Residence of Decedent	1 <b>2</b> 3 M 2□ F		35Yrs.	Months D	Days	Hours Min.		6,1965			
	10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d.	Inside City Limits	
2	MD N/	A		Baltin	ore						Yes 2 No	
Director	10e. Street and Number				10f. Zip Co	ode			10g. Citizen of V	What Country?		
	UN	KNOWN			U	JNK	NOWN		USA			
Funeral	11. Meritet Stetus	12. Wes De	cedent Ever in U	J,S. 13. V	Vas Deceden	t of Hi	spanic Origin? (Sp	(Specify Yes or No- 14. Race - America			ndien,	
N Fur	XXXVever Merried 2 Mar 3 Widowed 4 Divorced	If Yes (	2 No Give		t Yes, specify I□Yes 2√2			orto Rican, etc.)  Bleck, White, etc.  Specify: BLAC			K	
P -		t's Education	Dates.	16a Deced	lent's Usual C	Occupe	ation		16b. Kind of Bu			
Completed	(Specify only highe	st grede completed		(Give	kind of work o	done o	during most of work	ing				
E	Elementary/Secondery (0-12) 12th	College	(1-4or 5+)	Unemployed					N/A	1		
	17. Father's Neme (First, Middle,	Last)					18. Mother's Nam	e (First, Middle,	Meiden Suman	ne)		
To Be	Tommy Hunt						Estell	e Sear	CV			
	19e. Informent's Neme/Reletions	thip (Type, Print)		19b. Mailing Address (Street end Number or Rura					-	State, Zip Coo	de)	
the second secon	20a. Method of Disposition	TI-COUS	20b.	20b. Plece of Disposition (Neme of					20c. Location -	City of town,	State	
	Donetion 5 ☐ Other (5		n State	carrotory, cron	netory or onre	proc	1	11/16 Baltimore, MD				
	21. Signeture of Funeral Servica		N.I	ing Mei	M. Pa	Addres	Cem.	11/16	Balti	more,	MD	
	Nuccei Funeral Home										Inc.	
	2501 Gwynns Falls Pkwy. Balto., MD 21  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,  Approximate											
nlner	Immediate Ceuse (Finel disease or condition resulting in death)  Sequentially list conditions,	e	Due to (	Due to (or as a consequence of):					31			
Cal	Cause (Disease or Injury that initialed events									1		
-	resulting In death) Lest	d										
clar												
Physician/N	Pert II. Other significant conditi	ons contributing to	death but not re-	sulling in the ur	nderlying cau	se give	en in Pert I.	23b. Did t	30		e cause of death?  Iy 4 Unknown	
by P										The second		
Completed								24a. Wes	en eutopsy rmed?	availab	eutopsy findings ole prior to etion of cause	
d d								2000				
	Of Manager and							700		1780/1	es 2□ No	
	25. Wes case referred to medica examiner?	Hospital:	3.4			Othe	er:			ul az cena		
2 2	1 No 2 No 2 No 27. Manner of Death	11	Inpatient 2	ER/Outpatien			→ □ Nuising no	ome 5 Resid	dence 6 Oth			
Certification:	1 Natural 5 Pendii 2 Accident invest	onth, Day Year)	28b. Time of Injury F 0072	OUND 200	Worl	k? Yes 2) No	SUB	JELT W	JAS SH			
tific	3 ☐ Suicide 6 ☐ Could determ	ce of Injury - At h	nome, term, stra	eet, fectory, o	offica		28f. Location (S City or Tox	Street end Number, Stete) LIA	oer or Rurel Ru	oute Number, KOF		
S		ALLE	YNEXT	TO STR	EET			BLoom	STREET	BALTIM	ORE, MO	
	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due (Check only one)  2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.									ce, and due to the ceuse(s) end manner as stated.  curred et the time, date and place, and due to the cause(s)		
-	29b. Signeture end title of certific	r, /	7	29c. License number			a number		29d. Date signe	d (Month, De)	(, Year)	
	30. Name and address of person	7	Λ.D. 0.C.M.E.				NOVEMBER 13,2000					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** November 1:35 DM 17,2000 INNIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner Buthware Cit of Baltimore Hospital 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2 F Months Days Hours Min 219-26-694 80 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MORE Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 3916 238 Ave 21215 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 11. Marital Status Yes, Give 1 Never Married 2 Married à 1 Yes 2 No Specify py n ves, Give Year or Dates: 3 ₩Widowed 4 Divorced lac 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
tife. DO NOT use retired) 16b. Kind of Business/Industry Knownas Elementary/Secondary (0-12) College (1-4or 5+) use wife 10-46 NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middla, Last) nd Mental marked o Perdue Marcus anne 1ae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tntormant's Name/Relationship (Type, Print) Rolling 2124 Separtment of Health reportant: If Item 27 Hudson 2109 20a. Method Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ood law & Cemetery 111/25/00 Baito 4 □ Donation 5 ☑Other (Specify) ENTOMBMENT 21. Signature of Funeral Service Licenses 22. Name and Address of Facility tone west, Fuc larch Fureral 4300 Wabash Ave Dalto 21215 23a. Palt1. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or hear failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Multisystem Draan disease or condition resulting in death) Examiner Intravascular Coaquilation Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last use as the burial-tran The law requires that the death certificate be execu Due to (or as a consequence ot) Box ( P.O. Part II. Other atgniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Onknown teart Failure of Vital Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause ot death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was cese reterred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient edical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28c. Injury at Work? Division 1 Natural 2 Accident 5 Pending investigation after death.

Director: After in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) yd ui bellil 4 \ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Data signed (Month, Day, Year) 29c. Licanse number 29b. Signature and title of certifier 30. Nama and address of person who completed callse of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

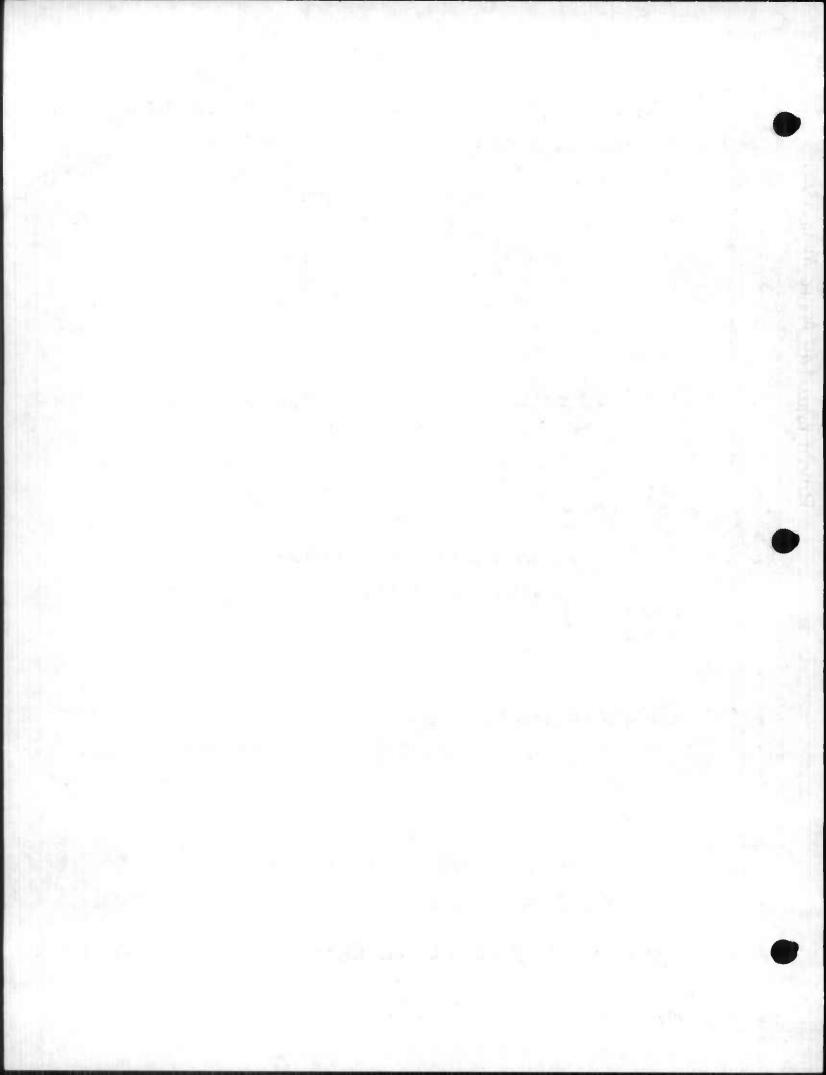
Registrar

31. Date filed (Month, Day, Year)

NOV 2 7 2000

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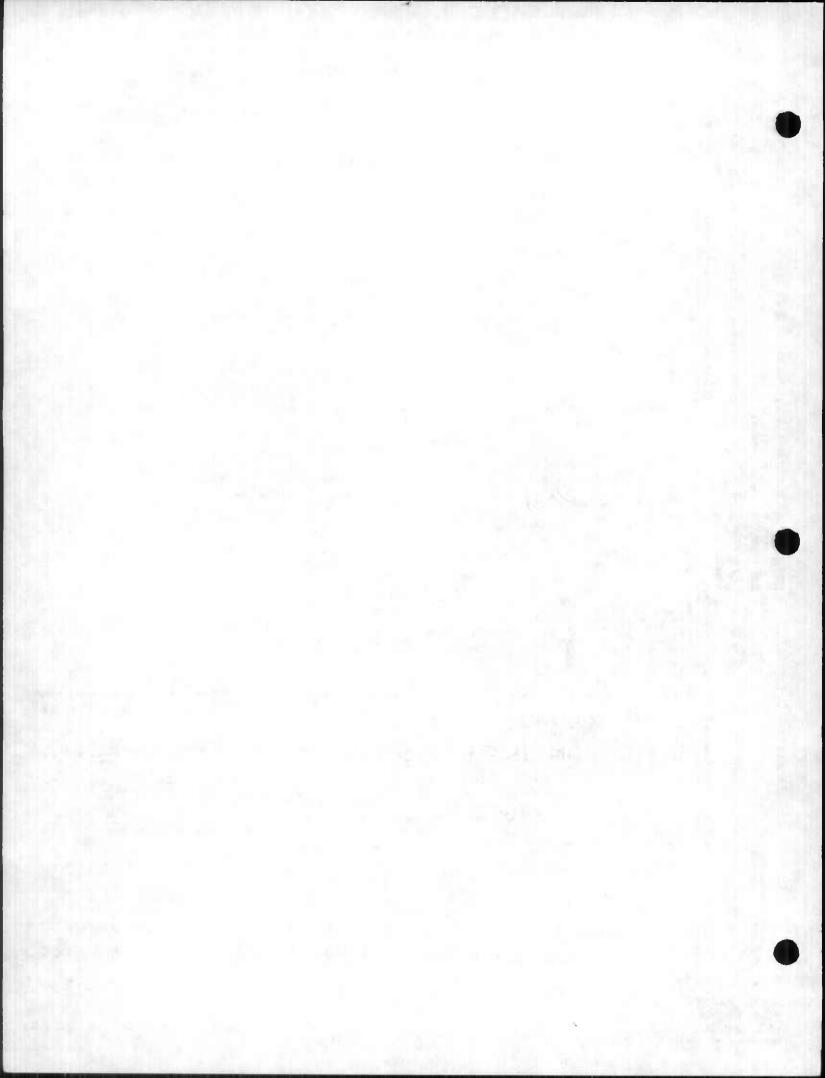
32. Registrar's Sonature



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	Certificate of Death	Reg. I	No.	7 1 2 0 1					
Dhusisis	Decedent's Name (First, Middle, Last)	2. Dete of Death	Day Yeer	3. Time of Death					
Physicia Medica/	VACK	NOVEMBER	23,2000	4:27A					
Examine	4a Facility Name (If not institution, give street and number) 4b. City, Town, or L	ocation of Deeth	4c. County of Death						
	JOHN HODKINS POYVIEW (US) TO THE THE LUSION AVAILED DOLLIMONES								
Funeral Director	220-22-4057 1X0 M 2 F 71 Yrs. Months Deys Hours Min.	8. Dete of Birth (Month, Day, Yes Oct. 29, 1	929 Sirthp Court Kern	lace (State or Foreign htty) Lucky					
pu a	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits					
Ba-f aho	Md. Baltimore Dundalk			1 ☐ Yes 2 No					
23a or 24	Md. Baltimore Dundalk  10e. Street and Number 7310 Berkshire Rd. 21222  11. Maritel Status 12. Was Decedent Ever In U.S. Armed Forces? 1 Never Married 2X		Citizen of Whet Cour	itry?					
urs a	3 ☐ Widowed 4 ☐ Divorced Year or Detes:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.					
72 ho	15. Decedent's Education 16a. Decedent's Usuel Occupetion (Specify only highest grade completed) (Give kind of work done during most of work	king 16b.	Kind of Business/Inc	dustry					
ithlu ithlu ithlu ithlu	Elementary/Secondary (0-12) College (1-4or 5+)	Ma	ryland S						
Hilled wi Hygien ther th	9 yrs. Printer	450-A AN	Buildin	ıg					
Man avan		ne (First, Middle, Maid	en Sumame)						
should nd Mer marke	OSCAT HALL  Mae  19a. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street and Number or Ru	Hoskins	v or Town. State. Zin	Code)					
and 2 selth ar 27 la	Betty Hall wife 7310 Berkshire Rd.								
parmit. Pages 1 end 2 should be filed within Department of Heelth and Mental Hygiere. Important: If Item 27 Ia marked other than any Injury or other traumatic avant, Ins. M.	20e. Method of Disposition  1 XBuriel 2 Cremation 3 Removel from Stete 4 Donetion 5 Other (Specify)  20b. Pleca of Disposition (Name of cametery, crematory or other pleca)  HOLLY Hill Cem.	1017 27	Locetion - City or To						
parmit. Pages 1 e Department of Hec Important: If item any injury or othe page.	22. Name and Address of Fecility Connelly Funera 7110 Sollers Po	l Home O	f Dundal 21222	k					
	23a. Part Ether the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec shock and failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between					
Physician /Medical	Immediate Ceuse (Finel disease or condition SEPTIC SHOCK			Onset end Death					
Examiner	disease or condition a. Due to (or as a consequence of):			0 110013					
	NEU TROPENIA			0 hours 2 weeks					
outed trans	Sequentially list conditions,  Due to (or as e consequence of):								
icate be executed physiclan end s the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest  Due to (or as a consequence of):  Due to (or as a consequence of):	THE TO	NGUE :	3 months					
- OI 0			1						
death e atte	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobac	co use contributs to	the causs of death?					
that the ned by the detache	HYPERTENSION	1 Tyss	2□ No 3 Pro	bably 4 Unknown					
The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	MYOCARDIM INFANCTION	24e. Was en eu performed	? av	ere eutopsy tindings ailable prior to mpletion of cause death?					
or Attanding Physician: The law requires that the death certain death.  Director: After this certificate has been signed by the attendir in by the funeral director. page 2 should be detached for use		1 ☐ Yes	2 × 10	Yes 2 No					
oftor.		th (Check only one)							
Physician: rhis certific ral director.	1 Yes 2 No Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence		y)					
ing Pi	27. Menner of Deeth 28a. Date of Injury 28b. Time of Injury 1 Neturel 5 Pending (Month, Dey Year) 28b. Time of Injury 28c. Inj	28d. Describe how In	njury occurred						
Hoopklat or Attanding Physician: The it hours after death. Fureral Director: After this certificate ha way filled in by the funeral director, page	2 Accident Investigetion 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)	28f. Location (Street City or Town, St		al Route Number,					
The Hospital		, and due to the cause rred at the time, date of	e(s) and menner as s end place, end due to	tated. o the cause(s)					
of the day	29b. Signeture and title of certifier 29c. License number	29d. I	Date signed (Month,	Day, Year)					
1X	Brodie, MP RES 00	O NO	VEMBER	23,2000					
24	30. Name and express of person who completed cause of deeth (Item 23e) (Type, Print)  DANIEL BRODIE 600 N. WOLFE ST, I	RACTINI	MOF ALD	21201					
State	31. Date filed (Month, Dey, Year) 32. Registrar's Signeture	7101/1100	rej Iva	0/					
	NO1/ 2 7 2000								

ORIGINAL

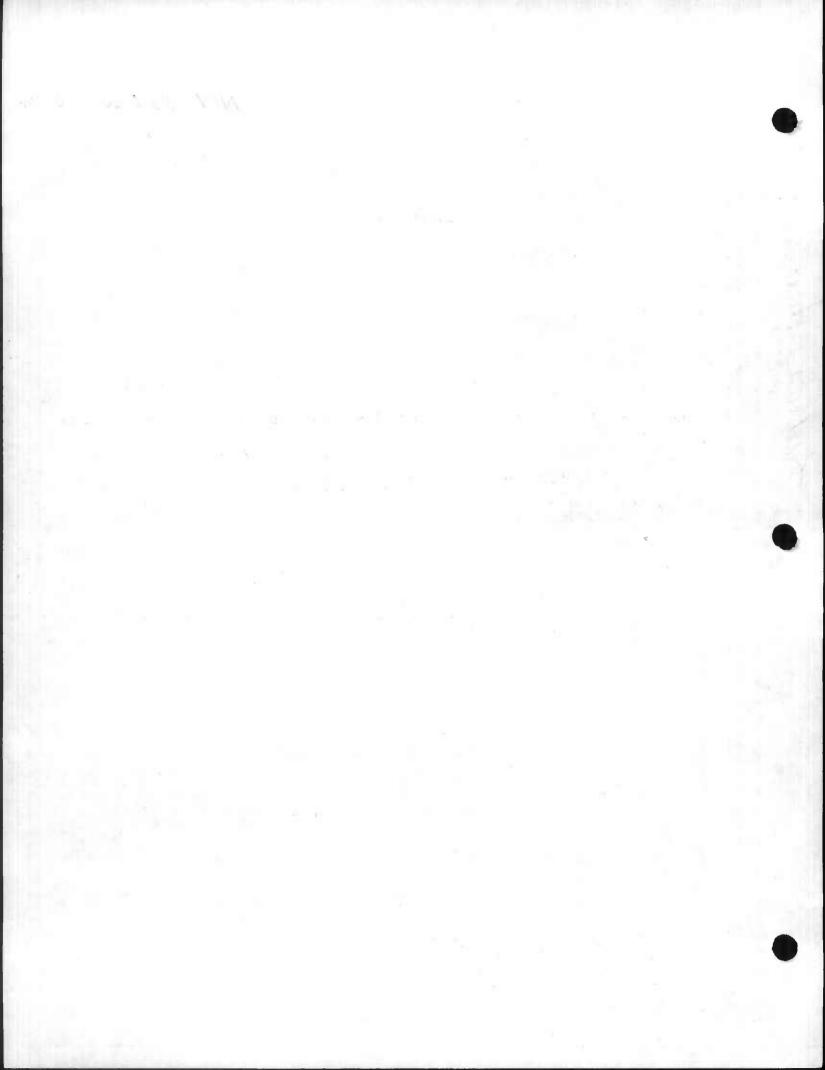


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death **Physician** 8:20 A.M. NOV 2000 LILLIAN O. HUNTER /Medical 4a Facility Name (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner WESLEY HOME Baltimore City If Under 1 Yaar 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Hours Months 216-68-5813 **Director** May 24, 1906 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director n/a Baltimore City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2211 West Rogers Ave. 21209 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 21215-0020 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be James Oswald Maydecker Browning 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marjorie McGee /daughter 1742 Stokesly Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlet 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Parkwood Cemetery 11/27/2000 Baltimore, MD 21. Signally of Fungual Service Private D. Coster 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc 1050 York Road Towson, Maryland 21204 23a. PSr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ARTERIO SCLEROTIC Box 68760 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown WITH POLYMYOGIT? S of Vital Records, by 24b. Were autopsy findings Completed 24a. Wes en eutopsy performed? DUMENTIA available prior to completion of cause of death? 2 D/No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? edicai Certification: To Be 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred or Attending Father deeth. Division 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident Director: J 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 2¢hours Funeral 29a. Certifiar Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the cause(s) and mannar as stated.

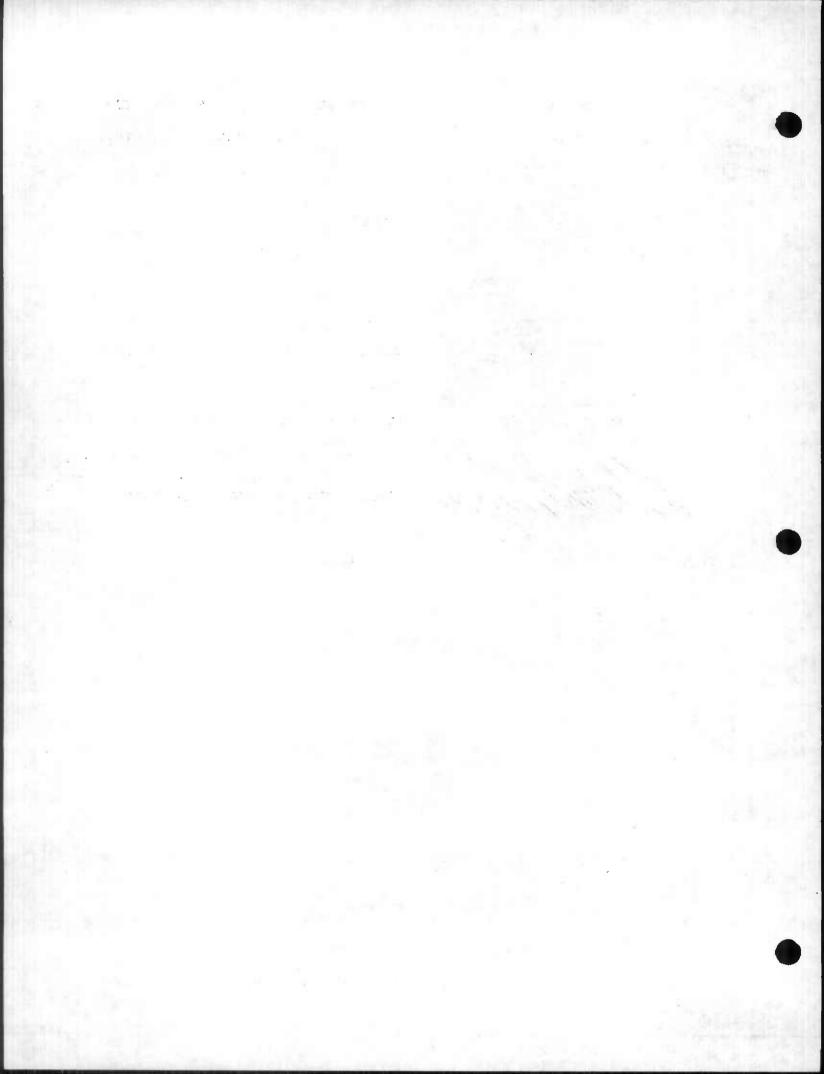
| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and placa, end due to the cause(s) and menner stated. To the To the 29b. Signatura and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed dause of deeth (Item 23a) (Type, Print) M.D -221 100Gers 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State NOV 2 7 2000 Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37263

	2 2 2	Certificate of Death Reg. No.											
		1. Decedent's Neme (First, Middle, L.	nst)				2. Dete of Death						
	Physician	NORMAN	JAY	Z	HANDLE	R	NOVEMBER						
	/Medical	4a Fecility Nama (If not institution, gi				4b. City, Town, or L	1	4c. County of De					
	Examiner	2 TOKAY COURT				RANDALL	STOWN	BALTIM					
-	- 1			n yrs. lest birthd	(ev) If Under 1 Yeer	If Undar 24 Hrs.							
	Funeral Director		1XM 2□ F	Ven	Months Devs	Hours Min.	8. Date of Birth (Month, Day, 1	'ear)	irthplaca (State or Foreign Country) N.Y.				
	Director	Usuel Residence of Decedent		55 "			Nov.27,19	944	IV-I-				
	Bud &	10a. Stete 10b. County	10	c. City, Town o	r Location	100			10d. Inside City Limits				
	l show	MD DAT MT	MODE	TO B A TO	ATT COMOUNT			1 ☐ Yes 2 No					
	oct of	MD BALTII	TORE	RAND	ALLSTOWN		140	g. Citizen of Whet C	````````				
	0 4 0				10f. Zip Code	22222	10	A	ountry ?				
	2 2 2	2 TOKAY COURT				21133		U.S.A.					
	72 hours are oearn with the maryand natural, or items 23s or 28s-f show dical Examinar mest be notified at eted by Funeral Director	11. Meritel Stetus	12. Wes Decedent Eve Armed Forces?	r in U,S.	<ol><li>Was Decedent of H If Yes, specify Cubs</li></ol>	líspanic Origin? (Sp an, Maxican, Puarto	ecify Yas or No- Rican, etc.)	14. Race - Am Bleck, Wh					
9	F P P	1 Nevar Married 2 Married	1 ☐ Yas 2 🛣 No		1□Yes 2ŽNo	Specify:		Specify:	WHITE				
00	"natural", o	3 Widowed 4 Divorced	Yeer or Detes:					ороспу.					
5-6	yglene.  Ner than "naturi nt, the Medical Completed	15. Decedent's E (Specify only highest gr		16e. De	ecedent's Usual Occup hive kind of work done fe. DO NOT use retired	ation	ina 16	6b. Kind of Busines	s/Industry				
21	then.	Elementery/Secondery (0-12)	College (1-4or 5+)	- lit	e. DO NOT use retired	1)							
21	or than		5+	FINA	ANCIAL ANAI	LYST		FINANCIA	L INVESTMENTS				
P	S SOLE	17. Fether's Neme (First, Middle, Las	1)			18. Mother's Nam	e (First, Middle, Me	siden Sumeme)					
<u>a</u>		DANIEL		HAND	LER	ADA			SCHNEIDER				
Maryland 21215-0036	E E E	19a. Informent's Neme/Reletionship	(Type, Print)	19b. M	lailing Address (Street	end Number or Rui	ral Route Number,	City or Town, Stete	, Zip Code)				
	and 2 is saith as in 27 is ser trac	CAROLYN HANDLER	WIFE	2 T	OKAY COURT	- RANDAL	r or Rural Route Number, City or Town, Stete, Zip Code)  NDALLSTOWN, MD 21133						
9	Department of Health important: If them 2 and Injury or other tra	20a. Method of Disposition		20b. Pieca of Di	isposition (Neme of	Dete 20c. Location - City or Town, Stete							
9		1 N Burial 2 ☐ Cremetion 3 [			crematory or other plea	11/22/00 FINKSBURG, MD							
Itin		4 Donation 5 Other (Special Service Lice	1 1//	DEIU ON									
Baltimore,	ny in	21. Signifige of yoneral sorviol Col	77		22. Name end Addre	50	L LEVINSO						
	20260	MAKABUK	Thusan		8900 REIST				MD 21208				
	4	23a Pert 1. Enter the diseasa, or complication the causad the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, sheck, or heart failure. List only one care from each line.											
Р	hysician		0 - 1	0					Interval Between Onset end Deeth				
	/Medical	Immediate Ceuse (Finel disease or condition											
E	Examiner	resulting in deeth)	4 (0)	e to (or es e cor	accuração of:	_							
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	physician and is the burishtransit edical Examiner		b	o to (or as e con									
-	errincate be executed ling physician and se as the bunsi-transit Medical Examin	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	D00	10 (0) 23 6 000	isequence ory.								
68760,	Siclar burn	Ceuse (Diseese or Injury that initieted events	C										
28	ling physicians to as the bu	rasulting in death) Lest	Due	to (or es a con	sequanca or):								
×	Z		d										
Bo	To the												
0	ed by the a detached by Physical	Part II. Other significant conditions	contributing to death but n	ot resulting in th	ne underlying cause giv	en in Part I.	23b. Dld tob	acco use contribu	te to the cause of death?				
<b>d</b>	ed by detac						1 □ Ye	• 2□ No 3□	Probably 4 Minknown				
S	2 68 2	5.000											
Record	been sign should be						24a, Was an perform		Were autopsy findings available prior to				
S S	4 0								completion of cause of deeth?				
I R	ate has page 2						1 ☐ Yes	2 1 No	1 ☐ Yes 2 ☐ No				
	8 a O	25. Wes case referred to medical				26 Place of Dee	th (Check only one						
5		examiner?	Hospital: 1   Inpatient	2□ ER/Outpe	etient 3 DOA Oth	oer.		nca 6 □Other (St	acity)				
0	ral di	27. Menner Deeth					28d. Describe hov		Journey)				
LO F	After fune	1 Patural 5 Pending investigation	28e. Date of Injury (Month, Dey Ye	ear) Inju		rk?  Yes 2 □ No							
Division	al Director: After ted in by the funers	3 Suicide 6 Could not l	De Disco of laive	At home farm			28f Location (Stre	eet end Number or	Rural Route Number,				
2	in by	4 ☐ Homicide determined	building, etc. (S	Specify)	, street, fectory, office		City or Town,	Stete)					
	Ca Line	29a. Certifier (Check only (Ch											
4		one)	end menner steted			A PART OF EACH							
F	Z con T con T	29b. Signatura and title of certifier	71	29	onth, Day, Year)								
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	0	30 Neme and eddress of person who	completed cause of deeth	(Item 23a) (Ty		1 (		1/					
	7	Louis MALINE	. ( . !	0/2/	aut R	d 5	sexe M	\$ 2120	8				
	State	31. Dete filed (Month, Dey, Year)	32. Registrer's	Signeture	1								
	Registrar	NOV 2 7 ZUUU	in place	19.	Ana Kal								

ORIGINAL



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:36 NOV **NELSON** CHARLES **JONES** 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 20 F Days Months 212-07-9195 85 October 17, 1915 Maryland Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location XX Yes 2 No Maryland N/A Baltimore 10a. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 3900 North Charles Street 21210 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XIX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify. XX Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elemantary/Secondary (0-12) Comptroller Bank 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 York Road Timonium Maryland 21093 Lawrence R Budd Attorney 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/22/00 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 nnes 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dylng, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death 140 cardial Infanction Immediate Cause (Final 3 minutes diseasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? lymphocytic leukaemia 1 DYes 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Panding investigation 1 Yes 2 No 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to tha causa(s) and mannar as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) manner stated. 29a, Certifier (Check only one)

been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate has page 2 Physician: After this within 24 hours a To the Funeral C completely filled Hospital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or lients 23s or 28s-f show edical Examiner must be notified at

The Medical Examiner

permit. Pages 1 and 2 aboutd be filed within 7. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "ne any injury or other traumatic event, the Medic 2008.

**Physician** 

/Medical

Examiner

Physician/Medical Examiner

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Certification:

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Baltimore,

Directo

Funeral

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Completed

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epital or Attending Physical after death.

neral Director: After this y filled in by the funeral di

State Registra

31. Date filed (Month, Day, Year) NOV 2 7 2000

laRian

29b. Signature and title of certifier

Rutialiano 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union Memorial Hospital

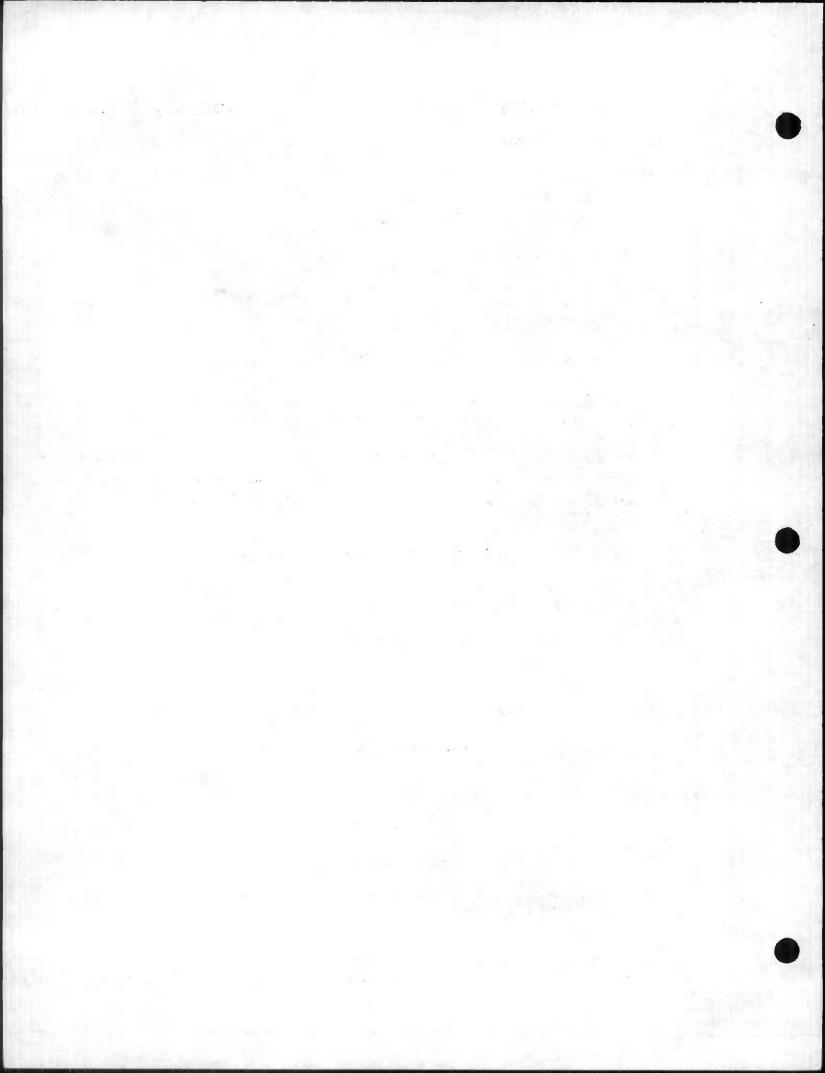
29c. License number

H0044296

29d. Date signed (Month, Day, Year)

November 19, 2000

**ORIGINAL** 



# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ves **Physician** 1.45 AN 2000 ONES 22 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner DAHIMORE recou 7 If Under 24 Hrs. 8. Date of Birth Hours Min. 8. Date of Birth Month, Day, 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10M 20 F Days 86 Yrs. Months 213-07-1057D VA Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location I is marked other than "natural", or items 23a or 28a-f show insumatic event, the Madical Examinar must be notified at 1 Ves 2 No Director MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death 1118 N. MONROE ST 21217 USA 12. Wes Decedent Ever in U,S.
Armed Forces?

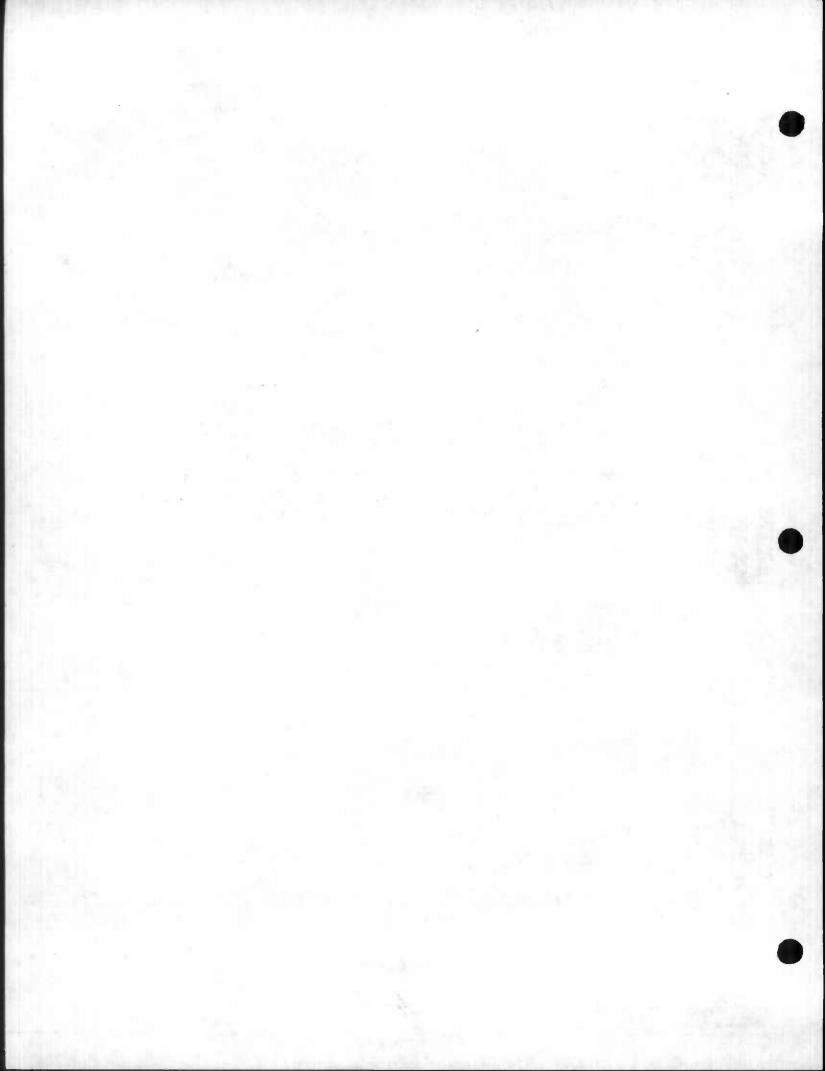
1 ☐ Yes 2 ② No
If Yes, Give
Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 10 HOUSEWIFE HOME permit. Papes 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Nem 27 is marked other
any Injury or other treumado event, 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Meiden Surname) LEE JOHNSON CLARKIE HARRIS 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1045 W. LEXINGTON ST. BALTO., MD. 21223 RUDOLPH RICE/GRANDSON 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State CEDAR HILL 11/28/2000 BALTO., MD. 4 □ Donation 5 □ Other (Specify) 21 Signature of Funerel Service Licensee 23 Ames and Address of Facility & SONS F.H., INC a. MM 1701 LAURENS ST. BALTO., MD. 21217 ames 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heer failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner EUMON /14 certificate be executed ed by the attending physician and detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): 1 Due to (or as a consequence of): requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 22 No 3 Probably 4 Unknown YPERCAICE MIA Division of Vital Records, P 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en eutopsy performed? peen aw has The 22 No 1 ☐ Yes 2 ☐ No 1 Yes certificate Physician: 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Neturel 2 Accident 5 Pending Investigation Injury or Attending after deeth.

Director: After d in by the fur 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Cartifier edical completely f and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL BAZEE EDWARD RCOURS DON 31. Date filed (Month, Day, Year)
NOV 2 7 2000 32 Registrar's Signeture 7

DHMH 16 Rev 6/95

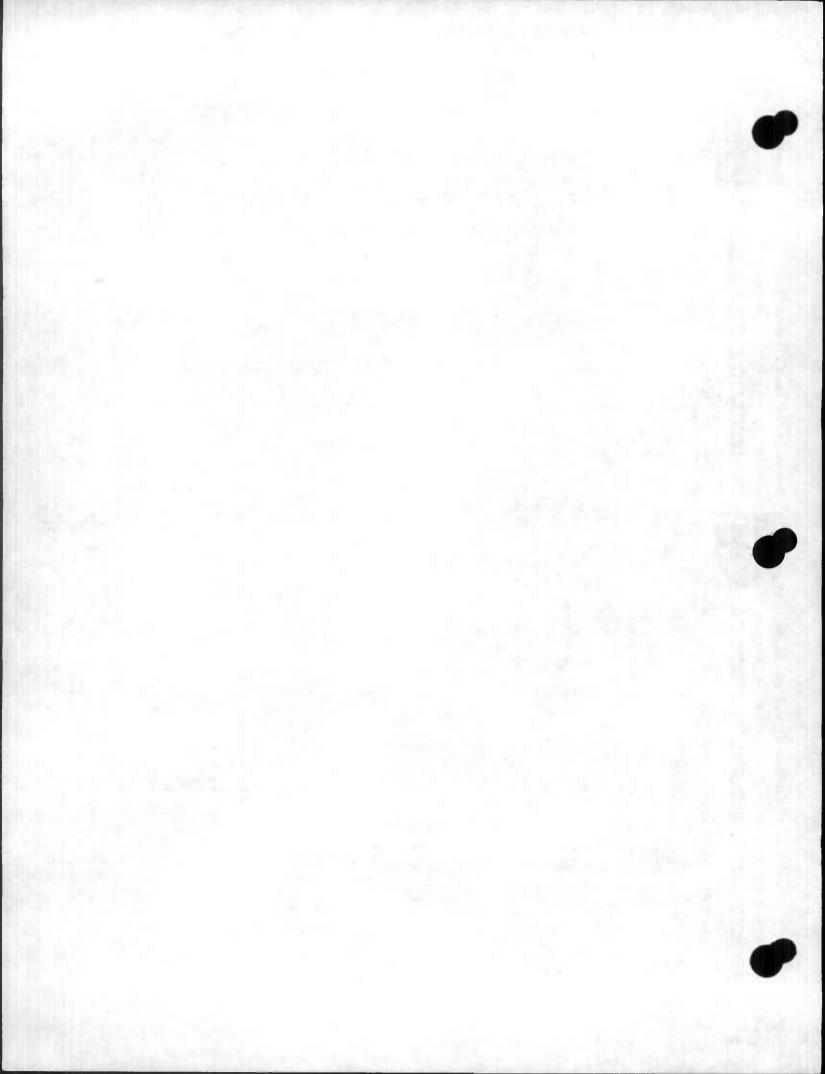
Registrar



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State of Maryland / Department of Health and Mental Hygiene 00 37266

				(	Certifica	ate of	Death		Reg. No.		1200		
_	ecedent's Neme (First, Middle, L	ast)		- 1222				2. Dete of D Month	leath Dey	Year	3. Time of Death		
cian lical	Norma Jaskilka							Novemb		2000	8:05 am		
iner 40 F	acility Neme (If not institution, gi	ive street and num	ber)				4b. City, Town,	or Location of Dea	ith 4c. County	of Deeth			
	Heritage Harbor	Health	and Re	habi	litati	ion	Annapo:	lis	Anne	Arun	del		
		Sex 1	. Age (In yrs.	last birth	Month	der 1 Yee		in. (Month, D	irth Dey, Year) 24,1919		ece (State or Foreign) necticut		
Usu	el Residence of Decedent							1142 011	21/1010	COIII	recticat		
10a.	Stete 10b. County	5 TO 10	10c. Ci	ty, Town	or Location					10d. Inside City Lir			
10e	MD Anne Ar	runde1	A	nnap	olis					100	10XYes 2 □ No		
10e.	Street and Number				10f.	Zip Code			10g. Citizen of Whet Country?				
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	15. Decedent's E			16a. [	ecedent's Usual Occupation live kind of work done during most of wo				16b. Kind of B	usiness/Ind	lustry		
	(Specify only highest g	rade completed)		1	Give kind of ife. DO NO	work don	e during most of t	working					
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	alter Blick						Eller	Humphri	98				
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	3   Suicide 4   Homicide  6   Could not be determined  28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify)							28t. Location (Street and Number or Rural Route Number. City or Town, Stete)			il Route Number,		
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29e 29b.	4 Homicide determine  Certifier (Check only one)  1 Certifying P 2 Medical Exa	buildin Thysician: To the barniner: On the barniner and menn	pest of my knows of exeminating stated.	etion end	or investigat	29c. Lice	opinion, death on the number of 642	ccurred et the time	29d. Date sign	and due to	Dey, Year)		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 7:05am 21, Nov. 2000 Jackson Ernestine 4a Facility Neme (ff not institution, giva street end number) 4b, City, Town, or Location of Death 4c. County of Deeth Baltimore 2822 Harford NA Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 1 M 20 F Yrs 58 12-30-41 261-64-1776 FL. Usuel Residence of Decede 10d. Inside City Limits 10a. Stata 10b. County 10c. City. Town or Location 1□Yas 2□No MD NA Baltimore 10a, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2822 Harford Road 21218 USA 12. Wes Decedent Evar In U,S. Armed Forces? 1 ☐ Yes ≥ 2 12 No If Yes, Give Yaar or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, White, etc. 1 Nevar Married 2 Merried 1 Yes 2√ No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) 11th Grade Housewife in home NA 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Tommy Johnson Lenora Johnson 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Veronica J. Green 2822 Harford Road Baltimore, Maryland 21218 20c. Location - City or Town, State MD . 20a. Method of Disposition 20b. Place of Disposition (Nema of cametery, cremetory or other plece) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville VA Cemetery 11-27-2000 Crownsville 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licenses Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth immediate Cause (Finel disease or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in deeth) Last Due to (or es a consequença of): Dua to (or as e consequence of): 23b. Did tobacco use contributs to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 Tho 3 Probably 4 Unknown nertension 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 28 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of fnjury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending investigation 1 Yes 2 No

Examiner certificate be executed pue attending physician for use as the buris Physiclan/Medicai ž signed by Records, by Completed Deen 2 9080 certificate has 2 of Vital Be Certification: To 918 **Innerti** Athar Division death.

**Physician** 

Examiner

**Funeral** 

Director

jons. r than "natural", or listins 23a or 28s-f show the Medical Examiner must be notified at

72 hours after

al Hygiene.

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permit. Pages 1 and 2 at Department of Health and Important: If Iban 27 is n

Physician /Medical

Examiner

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/Medical

Director

Funeral

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Completed

Attending after death Director: A d in by the f To the Hospital within 24 hours a To the Funeral C completely filled

State

edicai

Registrar

NOV 2 7 2000

29b. Signetura end fills of certifier

4 Homicide

3 ☐ Suicide

29a. Certifier

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Data signed (Month, Day, Year)

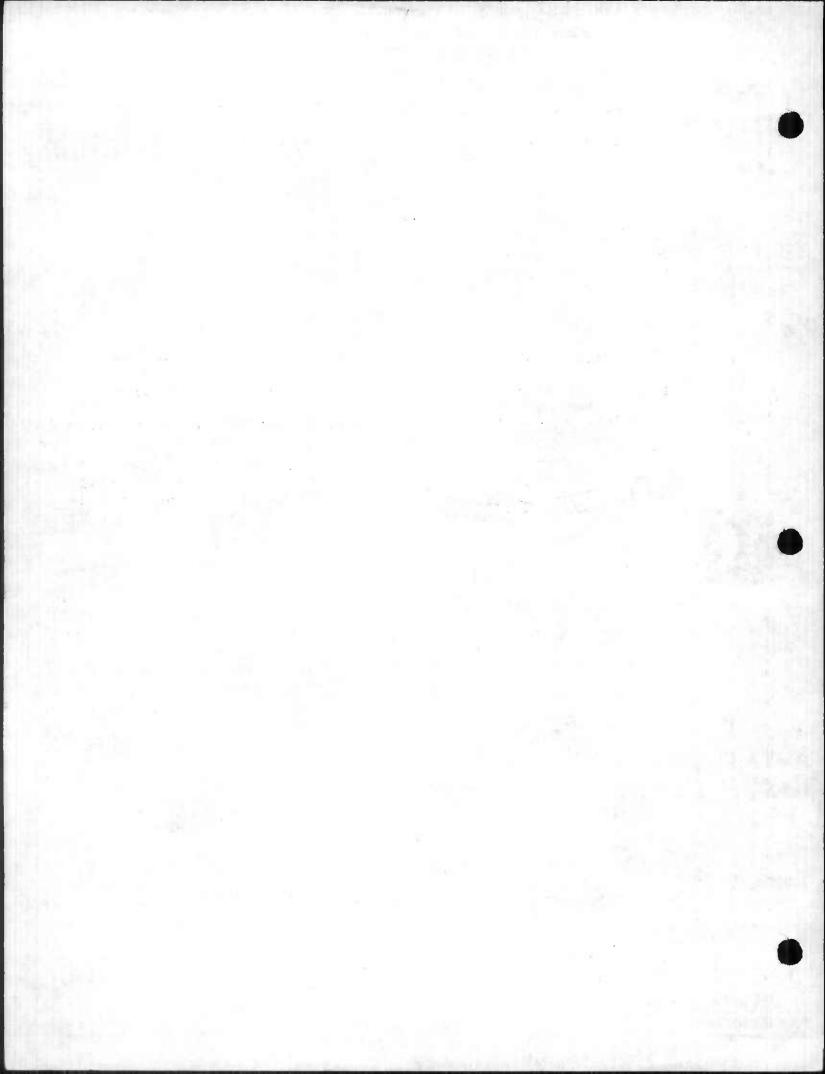
28f. Location (Street end Number or Rural Route Number, City or Town, Stele)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

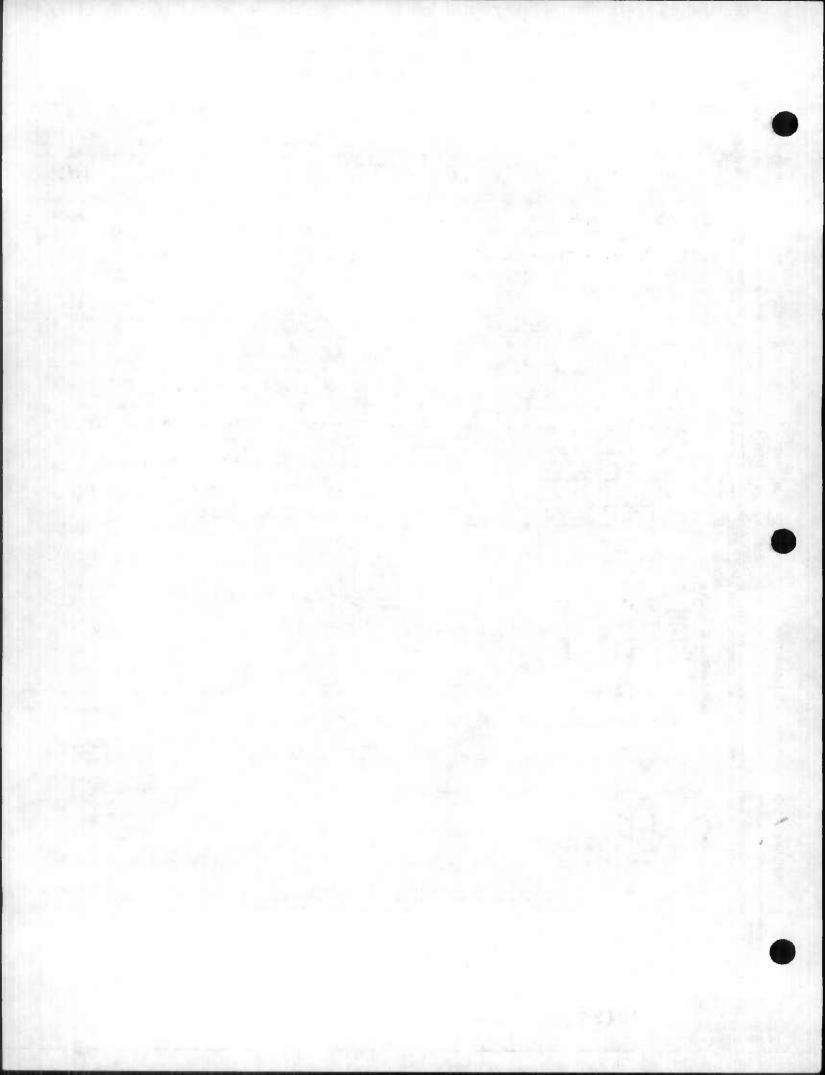
1enhan 32. Registrat s Signeture

ORIGINAL



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 2 6 8

				Certificate of	Death	Reg	g. No.	0 / 2 0	
	Physician	1. Decedent's Name (First, Middle, Last				2. Dete of Deeth Month	Dey Y	3. Time of D	
3	Physician /Medical	Walter	L. JONE	rs		Nov.	19 20		. Am
)	Examiner	4a Facility Neme (If not institution, give	street and number)		4b. City, Town, or Lo		4c. County of	Death	
		hevindale		hirthday) If Under 1 Yee	Baltino		NA		
	Funeral Director	5. Social Security Number 6. Se 241-16-3837	7. Age (In yrs. last I	Yrs. Months Days		8. Date of Birth (Month, Day, )	(ear) 1922	Birthplece (State or Country)	Foreign
	Mand Mand	10a. State 10b. County	10c. City, To	wn or Location			10d. Inside City Lim		
	t 28a-f show	MD NA	Bal	timore				1 Yes 2	2□ No
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	hours effer death with the Ma urel, or heme 23e or 28e f s effer miner must be notified effer by Funeral Director	11. Merital Stetus  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No if Yes, Give Year or Dates:	13. Wes Decedent of If Yes, specify Cu	Hispenic Origin? (Spe ban, Mexicen, Puerto Specify:	cify Yes or No- Rican, etc.)		American Indien, White, etc. Black	
2-0	n 72 hours natural', de leted b	15. Decedent's Edu		ia. Decedent's Usuel Occi	upation	10	6b. Kind of Busin		
218		(Specify only highest grad Elementery/Secondery (0-12)	College (1-4or 5+)	(Give kind of work don- life. DO NOT use retir	ed)	19	Fort	Meade	
121	of filed will Hygien other the vent, the	10.44	NA H	ir Condition					
Maryland	Mental H mrked oth artic even	17. Fether's Name (First, Middle, Last)			18. Mother's Name		1		
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Ma	thand thand 7 is m trsum	Ethel L. Jone	0 0		. 1	. 0	tto Ma	2.21225	7
e,	ges 1 and 2 should be filed with if of Health and Mental Hygiene. If flem 27 is marked other than or other traumatic event, the M To Be Comp	20e. Method of Disposition	20b. Place	of Disposition (Name of		-		ty or Town, State	
altimore	permit. Pages Department of Important: If I any injury or once.	1 Surial 2 Cremetion 3 F 4 Donetion 5 Other (Specify)	Hemoval from State	Sational	Hem Yk!	23/00/	aucel	, Hd	
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4	that the ded by detac	Pulmonan	Embolus			1 🗆 Ye	8 2□ No 3	Probably 4910	nknown
	The law requires that the death certained has been signed by the attending page 2 should be detached for use Completed by Physician/N					24a. Was an	autoney	24b. Were autopsy fin	ndinas
20.	shoul ete					perform		evailable prior to completion of ce	
Rec	stellen: The law s certificate has b director, page 2 s o Be Compil						-04	of death?	
= 1	ficate h or, page	25. Was cese referred to medical			an Division of Decision	1 Yes		1 Yes 2 N	10
Vital	Physician: this certific ral director,	evaminer?	Hospital: 1 Hipatient 2 ERV	Outpatient 3 DOA	26. Plece of Deatl	ne 5 Resider		(Specify)	
	4 E E	27. Menner of Deeth		. Time of 28c. Inj		28d. Describe hov			-
0	Attending ir death. ector: After by the fune lification	1 Natural 5 Pending 2 Accident investigation	(MONIN, Day Year)		Yes 2 No				
>	ar de recto recto by th	3 Suicide 6 Could not be determined	28e. Plece of Injury - At home, building, etc. (Specify)	farm, street, factory, offic	9	281. Location (Stre City or Town,	eet and Number Stete)	or Rural Route Numb	10r,
0	Ce is a fine of its of								
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com		elclan: To the best of my knowled ner: On the besis of examinetion of						
	ithin 2 on the comple	29b. Signeture and title of certifier	end menner stetled.	29c. Lice	nse number	29	d. Date signed /	Month, Day, Year)	
	F ≱ F 8	1 Anne	m. Non	- DE	2547		11/19/	11	
	7	30. Neme and eddress of person who co	ompleted cause of death (Item 22)	(Type   Print)	2/12	/	1/1//	70	
	2	Wan Di	-PN	Leun	dale				
	State	31. Dete filed (Month, Day, Year)	32./Registrar's Signature	1					
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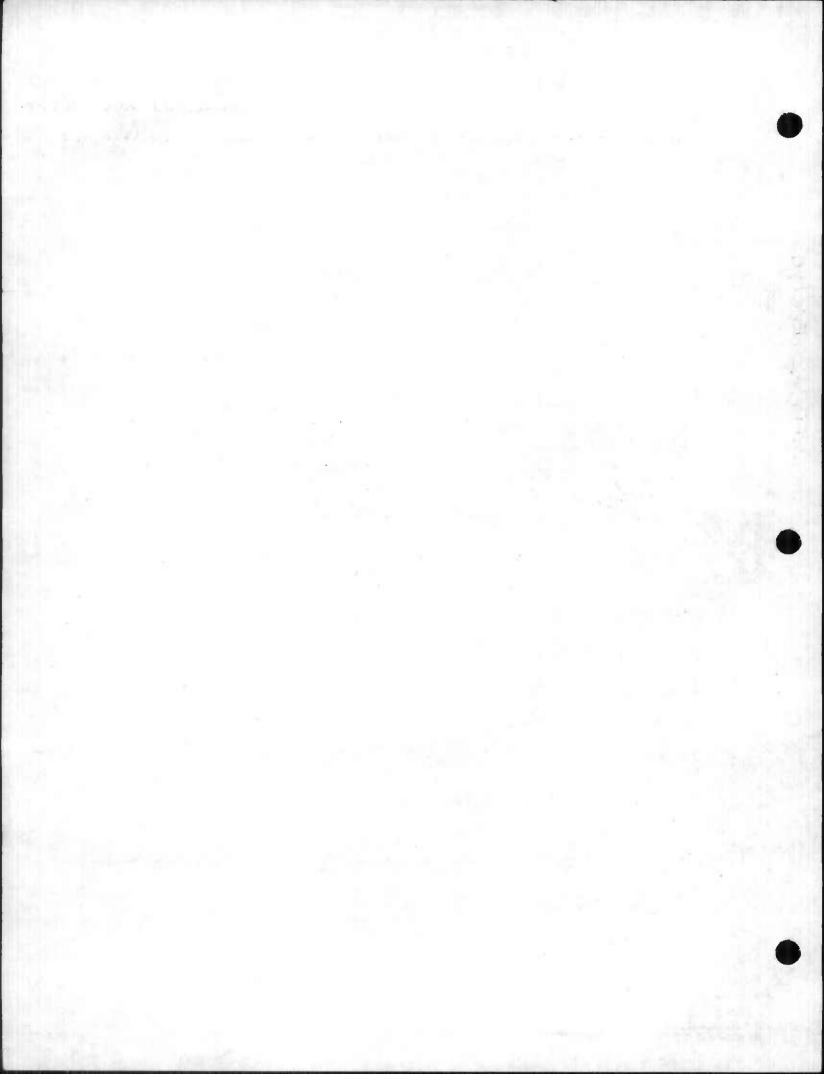


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hysician /Medical	HIVELVE M LOTTY 100									November 22 2000 803 F			803 PI		
Examiner		Name (If not institu			_	cent	0.5		ROSC		Location of Death 4c. County of Death				
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ral Director	10a. State	10b. Cou	,		10c.	City, Town or								10d. Inside City Lin	
Director	Ma.	Md. Baltimore Dundalk									1 Yas 25				
	10e. Street and Number 10f. Zip Code 21 22 2								10g. Citizen of What Country?						
Funeral	11. Marital						21222  3. Was Decedent of Hispanic Origin? (Specify Yas or Nif Yes, specify Cuban, Maxican, Puarto Rican, etc.)					USA o- 14. Race - American Indian,			
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by	3 □ Wid	3 □ Widowed 4 □ Divorced			If Yes, Give ^A Year or Dates:			SXI NO	Specify:			Specify: Whit			
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o Be		old Spi											eth Williams		
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DHMH 16 Rev 6/95

State Registrar



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State of Maryland / Department of Health and Mental Hygiene	3	1	2	1	0
Certificate of Death Reg. No.					

	Physician
	/Medical
ħ.	Examiner
_	

Direct permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Importants if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Physicia /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME BERNARD KNICH

Division of Vital Records, P.O. Box 68760,

			Oei	lineale c	Deall			Reg. No.		
Decedent's Neme (First, Middle     BERNARD	e, Last)	KNIG	HT				2. Date of Dec Month	ber 24	Yeer 1,2000	3. Time of Deat
4a Facility Name (If not institution	n, give street and n	umber)			4b. City, To	own, or Lo	cation of Death	4c. Count	y of Death	
5. Social Security Number	6. Sex	7 Ann //n um	. last birthday)	If Under 1 Ye	ar If Under	24 Hrs	-	h	N/A	nan /Ctata as For
	Months Da		Min.	8. Date of Birt (Month, Day		Count				
Usual Residence of Decedent							12-03-	-1924		MD
10e. State 10b. County		10c. C	ity, Town or Lo	cation		44,01			10	d. Inside City Lin
MD	N/A		BALT	IMORE						XXYes 2
10e. Street and Number				10f. Zip Cod	е			10g. Citizen of	What Count	ry?
831 EDMONDSON A	AVENUE			2120	01			USA		
11. Meritel Stetus	12. Wes De	cedent Ever in t	J,S. 13.	Was Decedent of f Yes, specify C	t Hispenic Or	rigin? (Spe	city Yes or No	14. Ra	ce - America	
1 Never Merried 2 Marr	ied 1 Yes	2/XNo					rucan, etc.)		ack, White, e	
3 □ Widowed 4 □ Divorced	If Yes, G	Dates:		1□ Yes 2∏XI	No Specify	:		Speci	<b>BLACK</b>	
15. Decedent			18a. Deced	dent's Usuel Oc	cupation			16b. Kind of f	Business/Inda	ustry
(Specify only highes			(Give	kind of work do DO NOT use re	ne during mo: tired)	st of worki	ng			
Elementary/Secondery (0-12)	College	(1-4or 5+)	TO	NGSHORE	MAN			SHIP	DINC	
17. Father's Name (First, Middle,	Lest)		LO	NGSHUKE		er's Name	(First, Middle,			
									,	
MANZZO JACKS			1				KNIGHT			
19a. Informant's Name/Relations				ng Address (Str						Code)
ELLA KNIGHT THO	DMAS/DAUG			5 N. LE		SALI	SBURY,	NC 281	44	
20e. Method ot Disposition				sition (Name of			Date	20c. Location	- City or Tox	vn, State
1 ☐ Buriel 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (S)		n State	MT. ZI			11	/30/200	O BATT	O MD	
21. Signature of Funeral Service				2. Name end Ad	dress of Fecil		1301200	ODALI	U. 9_FID	•
		1-	J.	AMES A.	MORTO	N & S	ONS F.F	H., INC		
Jame	oa, N	Jolly	1	701 LAU	RENS S'	r.,_B	ALTO.,	MD. 21	217	11. Car. 39
23a, Part1. Enter the dismase, or shock, othern failure. List	complications that only one cause on	caused the dea each line.	ith. Do not ent	er the mode of	dying, such as	s cardiac c	or respiratory er	rest,		Approximate Interval Between
										Onset and Deat
Immediate Cause (Final disease or condition	Ω	0.	T	P_'1	)				1	
resulting in death)	0	espera	or as a consec	rau	and				1	
	(	) . Dog 10 !	(or as a consec	juerice oi).	- 1	-1			1	
	b	oron	ary		uy d	Mea	Selve			
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if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	. (	and	estin	e Ke	art.	Lan	lure			
that initieted events resulting In death) Last		Due 19	or es a conseq	uence of):						
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	d	Corce	mora	orace	MC (	ver	men	1		
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^	Venno	AMARK	0.0				perfo	med?	ava	ilable prior to
										leath?
		S					10	Yes 2000	10	Yes 20 No
25. Was case reterred to medical					26. Pled	e of Deeth	n (Check only o	one)		
examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA	Other:		me 5 Resid		ther (Specify	•)
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1 ☑Natural 5 ☐ Pendin	g (Mo	nth, Day Year)	Injury		njuryat Work? I∐Yes 2 ☐					
2 Accident Investig	not be						not treation (	Carran a mark a few	a have an Deem	Davida Abrashas
4 ☐ Homicide determ	ined 208. Plac	e of Injury - At I	home, ferm, str ify)	eet, factory, off	Ce		City or To		n <i>ber of Hur</i> a	Route Number,
	g Physician: To th									
one) 2 Medicat	Examiner: On the and ma	nner stated.	etion and/or in	vestigation, in n	iy opinion, de	eth occurr	ed at the time,	dete end place	, and due to	tne ceuse(s)
29b. Signature and title of certifier			0	29c. Lic	ense number			29d. Date sign		
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31. Date filed (Month, Day, Year)	a 32.	Registrar's Sign	nature /							

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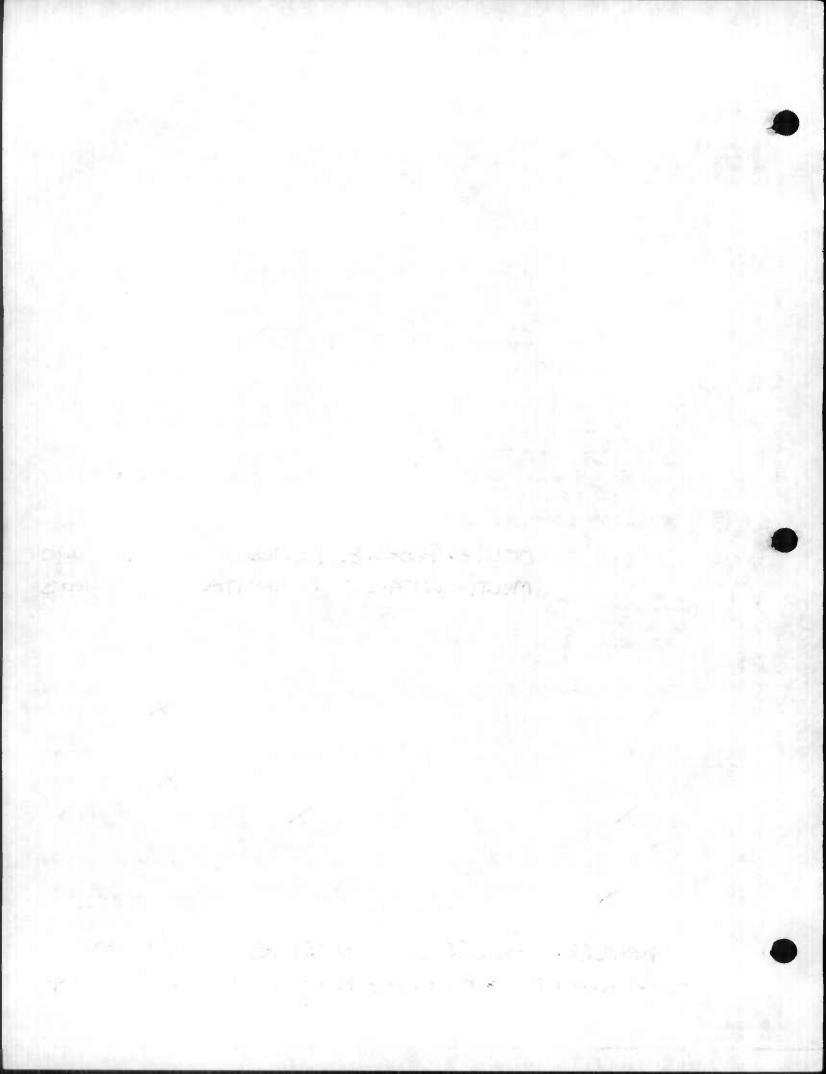
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Sporks

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 19 Florence Abigail Knell November 2000 7:05 PM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Baltimore Oak Crest Village - Care Center Parkville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Days Months 1 M 2 XF 218-09-2049 Yrs. 84 Director April 18, 1916 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Glen Arm Maryland 1 ☐ Yes 2 No Director 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò must be 21057 United States 4102 Ravenhurst Cir. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Meritei Status 1 □ Never Merried 2 □ Married 8 Specify: White 21215-0020 1 ☐ Yes 2 No Specify: by 3 X Widowed 4 □ Divorced 72 hours Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiens. Elementery/Secondery (0-12) College (1-4or 5+) hairdressing hairdresser Maryland 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Lillian Vance Anthony Fowler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 4102 Ravenhurst Cir. Glen Arm, MD 21057 Health Ham 27 I Walter L. Knell/son Baltimore, 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Greenmount Crematory 11/21/00 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 21. Signeture of Funerel Service Licensee 1/IV 6500 York Rd. Baltimore, MD Approximete Intervel Between Onset end Deeth 23e. Fart1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. **Physician** Immediate Cause (Finat disease or condition resulting in deeth) /Medical Examiner Examine Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat 26. Plece of Deeth (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Deet! 28d. Describe how injury occurred 1 Neturet 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 (ttem 23a) (Type, Print) 8800 willen, 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Month 1130 AM **Physician** Zoco NOVEMBER 22 MARIE ANNA KREISEL /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE CITY BALTIMORE CITY 3607 Mary Avenue If Undar 1 Yaar | If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Funeral 10 M XOF 220-07-1910 91 6-13-1909 Director Maryland Usual Rasidence of Decedant the Maryland 10d. Inside City Limits 10a, Steta 10b. County 10c. City, Town or Location 28a-f show th and Mental Hygiene. 7 Is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Baltimore City Baltimore City 1 Yes 2 No Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 21206 USA 3607 Mary Avenue Funeral filed within 72 hours after death 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Merital Status 12. Wes Decedant Evar In U,S. Armed Forces? Black, White, atc. 1 ☐ Yas XX No 1 Never Married 2 Merried Specify: White 1 ☐ Yas XX No Specify: þ X X Widowad 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) I Lot Saleslady 8 yrs. permit. Pages 1 and 2 ahould be filed.
Department of Health and Mental HvmImportant: if item 27 is marken
any injury or other. Maryland 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fether's Nama (First, Middle, Last) Lilly Wiegand Gustav Doehring 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 36 East Melrose Avenue Baltimore, Md. 21212 David C. Kreisel (Son) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 11-25-2000 Baltimore, Md. Parkwood Cemetery 21. Signature of Fonaral Sarvice Licensee 22. Name and Addrage of Facility Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting In daath) /Medical MYOCARDIAL INFARCTION **Examiner** Due to (or as a consequence of) Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last the attending physician and hed for use as the burial-tran Dua to (or as e consequance of): 68760, Due to (or es e consequance of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco uss contributs to the csuss of death? 1 Yes 2 No 3 Probably Unknown signed by CONCESTNE HEART FAILURE. ATRIM FIBRILLATION. of Vital Records, 24b. Were autopsy findings evailebla prior to completion of cause of death? 24a. Wes an autopsy performed? HYPERTENSION this certificate has 1 Yas 2 No 1 ☐ Yes 2 No apital or Attanding Physicien: Theoris after death.

neral Director: After this certificate y filled in by the funeral director, pa 25. Was cesa rafarrad to medicel axaminar? 26. Placa of Death (Check only ona) Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Medical Certification: 28b. Tima of Division 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accidant 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital
Within 24 hours a
To the Funeral C
completely filled 29a. Cartifian Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifie 29c. Licensa number 10053095 NOVEMBER ZZ, ZUOO 30. Nama and addrass of person who compiated ceusa of daath (Itam 23a) (Type, Print) 2360 W. JOPPA RO. #302 LUTHERVILLE, MARYLAND ZIO93 J. CARR MO

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State

Registrar

31. Data filad (Month, Day, Year)

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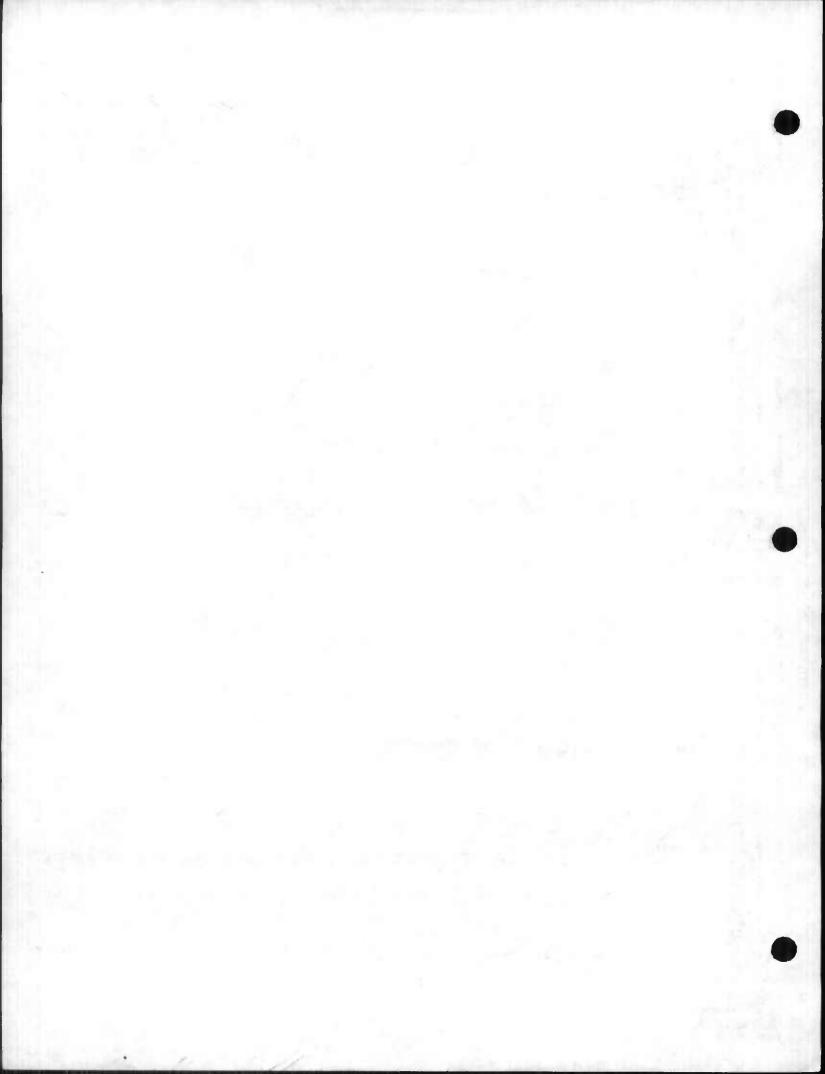
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**ORIGINAL** 

32, Registrar's Signature



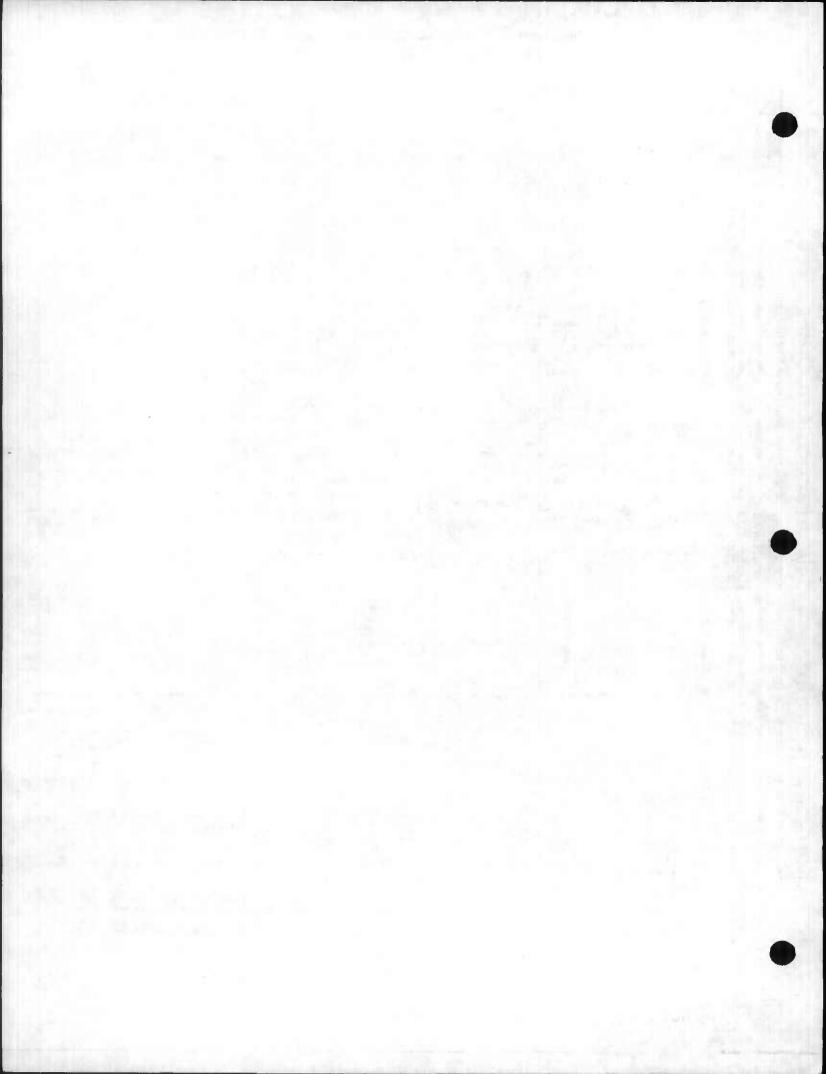
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	Physician /Medical	Ida Marie Kess	sler						Nov.		000	4:20 AM
	Examiner	4e Facility Neme (If not instituti	on, give street and num.	ber)				4b. City, Town, or	Location of Deal		of Death	
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	Funeral Director	5. Sociel Security Number 214–14–9722	6. Sex 1 M 2 F	'. Age (In yrs. 88	last birthday)  Yrs.	If Under Months	1 Year Deys	If Under 24 Hrs Hours Min.		rth sy, Year) 5, 1912		elece (Stete or Foreign etry) ginia
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an an	Monta or Manda or Monta	Charles Harri	son					Gertru	de Swanr	)		
and and	T THE P	19a. Informent's Neme/Reletion			19b. Maili	ng Address	(Street	and Number or Ru		-	Stete, Zip	Code)
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	6	30. Name and address of person	who completed cause		m 23a) (Type, Rolling	Print)	cca	Caten	sille	isam	228	2,2000
	State Registrar	31 NOV 2 M 2000	Server 32. Res	gistrer's Sign	ature So.	acks						

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# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 2 7 4 Certificate of Death

					Cer	uncate	OI L	Jealli			Reg. No.		
	Physiciai /Medica	Total Contract	die, Last) Koma	r						2. Date of De Month Novemb	per Day 5, 2	000	3. Time of Death 4:00 A.M.
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7	o o o o o o o o o o o o o o o o o o o	19a. tn/ormant's Name/Relation	nship (Type, Print)	111111111111111111111111111111111111111	19b. Maitin	g Address (S	reet e	nd Numb	er or Rura	al Route Numb	er, City or Town	State, Zij	Code)
	C TO PM AN	Mrs Evelyn M.	Komar (Wi:	fe)	203	Meado	vva	le R	oad 1	Lutherv	ille, M	aryla	nd 21093
	mit. Pages 1 and partment of Health portant: If New 27 y Injury or other to	20a. Method of Disposition		20b.	Place of Dispo	sition (Name	of			Date	20c. Location		
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n		23a. Part1. Enter the disease, shock, or heart teilure. Li	or complications thet	t caused the dee	th. Do not ent	er the mode o	dying	, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
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Komo	D PP C	27. Manner of Death		e of Injury onth, Day Year)	28b. Time of Injury	28c.	Injury Work	et ?		28d. Describe	how injury occu	rred	
7	Barre a	1 X Naturat 5 Pend 2 Accident inves	tigation	, and , can,	unjanj	M		res 2	No				
0 1	Alta Dy S Clo	3 Suicide 6 Coule 4 Homicide	mined 200. Flat	ce of Injury - At h	nome, farm, str	eet, factory, o	fice			28f. Location	(Street and Num	ber or Rur	al Route Number,
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			ing Physician: To th	he best of my kno	owledge, deeth	occurred et t	he time	e, dete er	nd plece,	and due to the	cause(s) and m	anner as	stated.
	24 Pru		I Examiner: On the										
	<b>申正事</b>	29b. Signature and 100 of confi	lar ,	1	0	29c. L	cense	number			29d. Date sign	ed (Month,	Day, Year)
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	Registra	A L CUUU	A Property of the Parks		KUSJOUL	163							



Please

Type or Print in Black Indelible ink. Assure State of Maryland / Department of Health an Certificate of Death		37275
s() Kowalevicz	2. Dete of Deeth Month Dey Yeer November 23, 2000	3. Time of D 4:30 p

7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examinar must be notified at Directo Funeral p

**Physician** /Medical **Examiner Funeral** Director

Completed

with the Maryland Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23 ury or other traumatic event, the Medical Examinations. permit. Page Department of Important: If any injury or once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

certificate be executed physician and s the burtal-tran 뵘 for use as ž signed by law requires peed certificate has page 2 å After this

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical g Completed Be 10 Certification: Attending 3 à Medical

1. Decedent's Neme (First, Middle, La Marie Elizabeth 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Heritage Center Dunda1k If Under 24 Hrs If Under 1 Year 8. Dete of Birth (Month, Dey, Aug. 8, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Deys 1 M XXF Months Hours 1918 82 215-24-3104 Mary land Usuel Residence of Decedent 10a. Stata 10c. City. Town or Location 10b. County Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 21 Lombardy Drive 12. Wes Decedent Ever in U,S. Armed Forcas?

1 ☐ Yes 2 ☐ No If Yes, Giva X Yaar or Datas: 14. Raca - American Indien, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Meritel Status 1 □ Never Merried 2 □ Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Waitress Restaurant 8 years 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Maria Baran Anton Gall 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 21 Lombardy Drive Dundalk, Maryland 21222 Mrs. Loretta Funk (Daughter) 20b. Plece of Disposition (Neme of cemetery, crematory or other p Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1∑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Gardens of Faith Cemetery 11/27/00 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 The the disaesa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, or heart feiture. List only one cause on each line. Gangrene Left Leg Immediate Cause (Final disaese or condition resulting in deeth) Due to (or es e consequence of): Peripheral Vascular Disease Sequentielly tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): Essential Hypertension that initiated events resulting in death) Last

Dua to (or as a consequence of) Diabetes Mellitus

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. Coronary Artery Disease

Hyperlipidemia

1 Yes 2 No 3 Probably X Unknown 24e. Wes en autopsy performed? 1 ☐ Yes 2X No

26. Place of Deeth (Check only one)

24b. Were autopsy findings eveilable prior to completion of ceuse of death?

1 Yas 2 No

Approximate Interval Between Onset end Deeth Months

12 years

25 years

years

20

23b. Did tobacco use contribute to the cause of death?

.m.

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

25. Was case referred to medicel 1 ☐ Yes 2X No 27. Menner of Deeth

1 Naturel

2 Accident

4 Homicide

3 Suicide

29a. Certifier

5 Pending Investigation 6 Could not be 28e. Dete of Injury (Month, Dey Year)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture and title of cartifier

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. Licansa number D0014160 29d. Date signed (Month, Day, Year) 11/24/2000

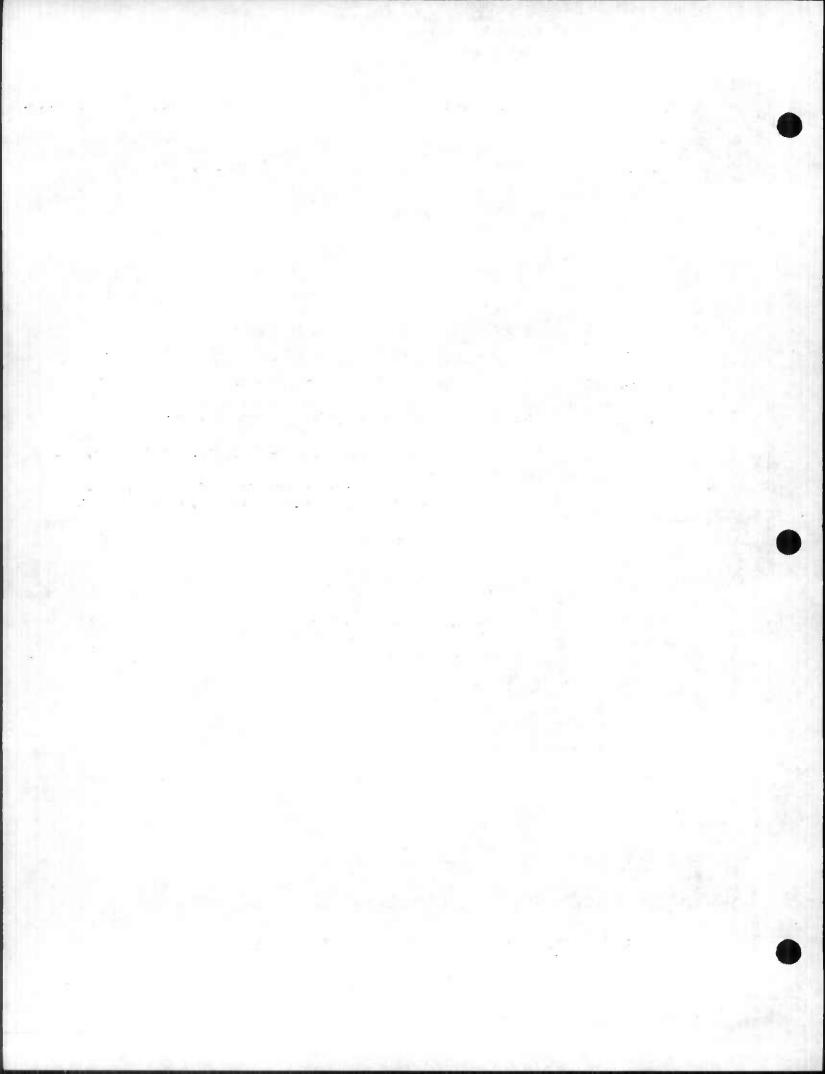
30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

State Registrar

31. Dete filed (Month, Day, Year)

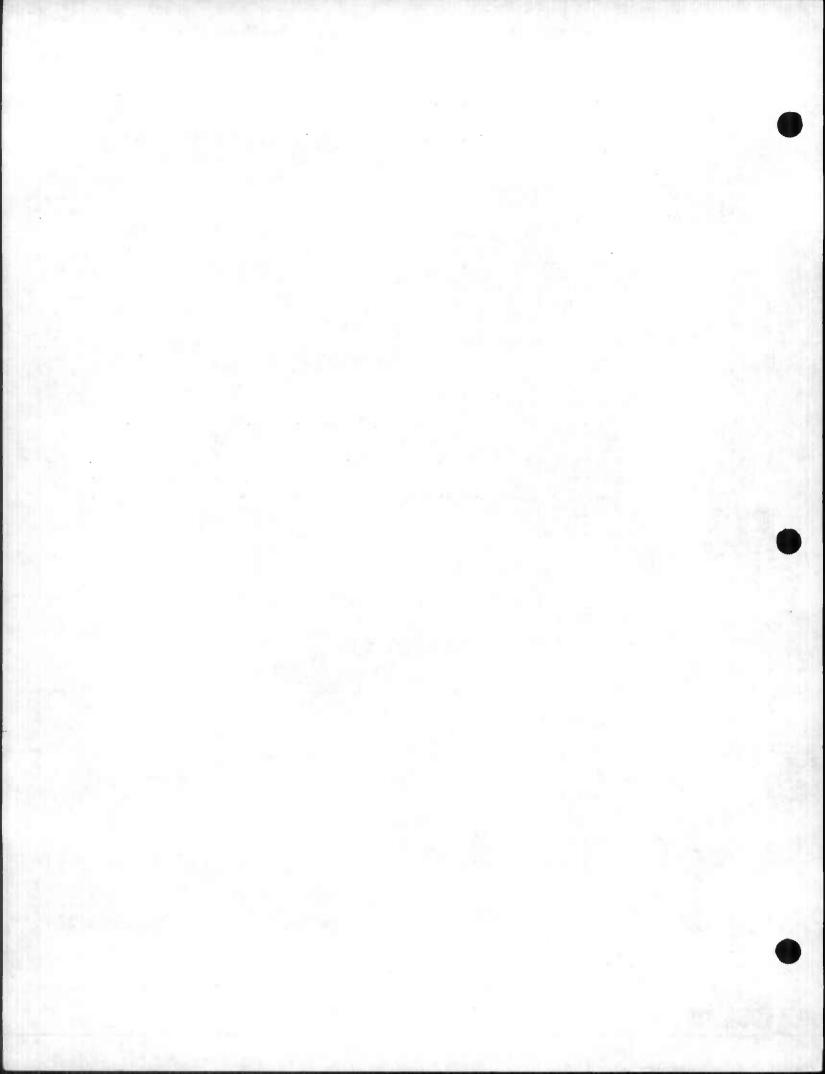




State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Marie Rita Connor Lingg November 24,2000 11:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Villa Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | 9. Birthplace (Sountry) | Nonths | Deys | Hours | Min. | June 23, 1912 | Wash. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 219-03-0682 88 Director D.C. Usuel Residence of Decedent 10a Stete 10c City Town or Location 10b. County 10d, fnside City Llmits 7 is marked other than "natural", or hama 23a or 28a-f show traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Ellicott City Directo Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3718 Meadowvale Court 21042 U.S.A. Funeral death 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0036 1 ☐ Yes > No Specify: Specify: White à 3℃Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) State of Maryland Social Worker permit. Pages 1 and 2 should be fild Department of Health and Mental Hy Important: if item 27 is marked othe any injury or other traumatic avant, DDGs. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Alexander P. Connor Eugene Gallenne 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 706 Clover Avenue, Baltimore, Maryland 21221 Laurence V. Lingg Jr. (son) 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) Nov. 28, 20c. Location - City or Town, Stete 1 X Burlei 2 ☐ Cremetion 3 ☐ Removal from Stete Parkwood Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licensee ann 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) DUXIa 5 min Examiner bue to (or as a consequenca of): Physician/Medical Examiner years ancutor CNIC attending physician and for use as the bunal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (of as e consequence of): Box 68760 Meylotabrosis 10 years Due to (or es a consequence of): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas contributs to the causs of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Tomino Records, ð The law requires 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed peen : page 2 s has certificate ! 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this funeral 28e. Dete of Injury (Month, Dey Year) 28b. Time of Certification: 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred After or Attanding s after deam. 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical completaly (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 126 2000 D50835 11 a mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5411 010 Frakerick Rd Suite 18 Boltimore markered 21229 William Davdo mo 32. Registrar's Signeture 31. Date filed (Month, Dey, Year) State 7 NOV 2 2000 Registra

DHMH 16 Ray 6/95

**ORIGINAL** 

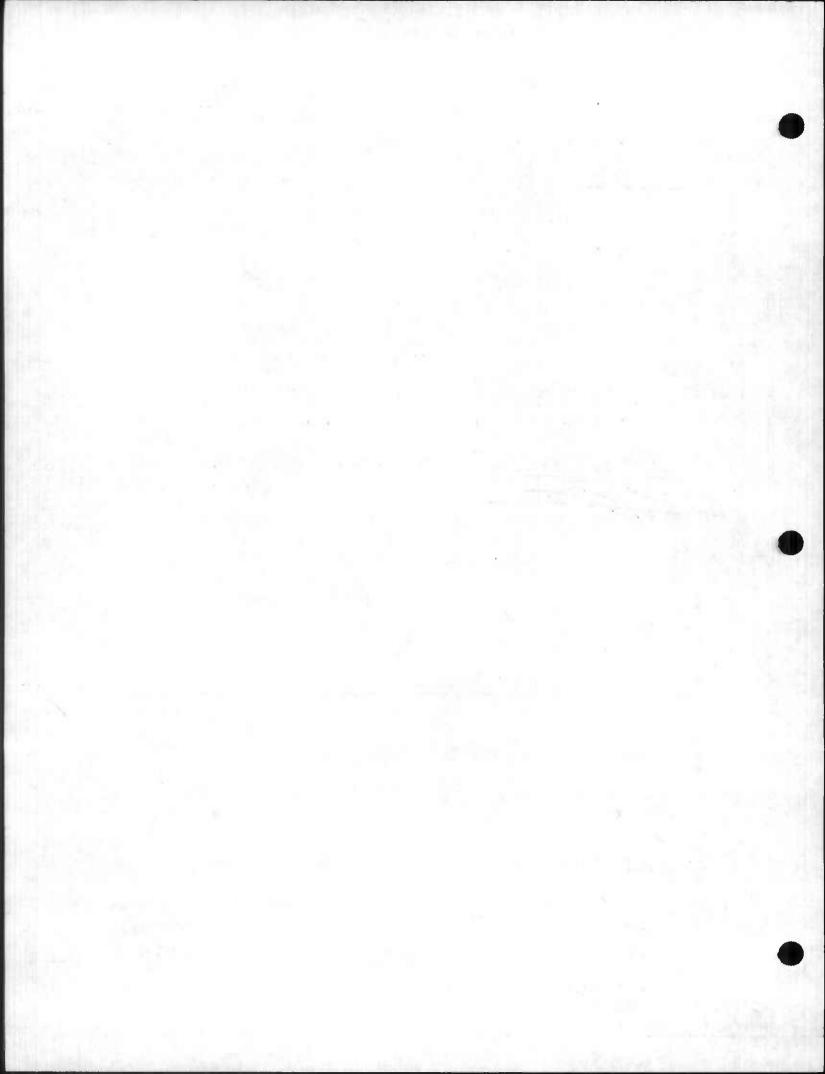


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37277 Certificate of Death Reg. No. 2. Dete of Deeth Day Year Month Day Year November 24, 2000 2:15 a.m.

nysician Medical xaminer	1. Decedent's Neme (First, Middle, L H. Jack Lathrop										
								2. Dete of De Month Novemb	er 24,	Year 2000 2	Tima of Death 2:15 a.m.
	4a Fecility Neme (If not institution, g		)			4b. City, T	own, or Loc	ation of Deat	h 4c. County	of Deeth	
· ·	902 North Woodwar	rd Drive				Essex			Balti	more	
neral	Social Security Number     6.		ge (In yrs. lest birth		Inder 1 Yes		Min.	8. Dete of Bir (Month, De	th Year)	9. Birthplace	(State or Foreign
ector	303-16-8473	12 M 2□ F	84 Y	rs.	itiis Dey	s Hours	PVIIII.	Nov. 6	, 1916	Oklaho	
-8	Usuet Residence of Decedent								1 .2	0.110110	
	10a. State 10b. County		10c. City, Town	or Location	1				F. C.	10d.	Inside City Limits
ō	Maryland Baltimon	re	Essex							7	1 ☐ Yes 2 No
8	10e. Street and Number			10	f. Zip Code				10g. Citizen of	What Country?	
Funeral Director	902 North Woodway	rd Drive			21221			100	U.S.		
ra								W M AI			- 4:00
nue	11. Meritel Stetus	12. Was Deceden Armed Forces	?	13. Was L	specify Cu	Hispanic O iben, Mexica	rigin? (Specin, Puerto F	city Yes or No lican, etc.)	)- 14. Hec	e - American I ck, White, etc.	naien,
	1 Never Married 2 Merried	1 ☐ Yes 2X If Yes, Give	No	10 Y	es 2KIN	o Specify			Specif	V. 1. 1.	
20	3 to Widowed 4 □ Divorced	Year or Detes:								white	2
ě	15. Decedent's I (Specify only highest g	Education	16a. l	Decedent's	Usuel Occ	upation le du <i>ring</i> mo red)	st of workin	0	16b. Kind of B	usiness/Indust	ry
Completed	Elementery/Secondery (0-12)	College (1-4or	5+)	life. DO N	OT use reti	red)	30 07 17011111	9			
5		2		ality	Assu	rance			Electro	onics	
0	17. Father's Neme (First, Middle, Las	it)					er's Name	(First, Middle	, Maiden Suman		
o Be	Horace Lathrop					Alic	e Bro	T. 773			
Ĕ	-		1					-		O T. O.	
	19a. Informant's Name/Reletionship								er, City or Town		
	Suzane Schnabel	(daughter)					Driv	e, Ess	ex, Mar	yland 2	21221
	20e. Method of Disposition		20b. Pleca of I	Disposition cremetors	(Name of	lece)		Dete	20c. Location	City or Town,	State
	PSuriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec		Holly H				e 111	127/20	100 Pal+	imoro	Maryland
		**	norry r				5 11	121129	ou bait.	more,	maryrand
1	21 Signature of Funeral Service Little	aritee		22. Nen	Bru	zdzins	ki Fu	neral	Home, P	.A.	
1				140	7 014	Faste	rn Av	enue.	Essex,	Marylar	nd 21221
	Part Enter the disease, or common or heart failure. List only	mplicetions thet cause	d the deeth. Do no	ot enter the	mode of d	ying, such e	s cardiec or	respiretory e	errest,	, Ap	proximete
	or heart failure. List ont	y one cause on eech	line.	1							erval Between set end Deeth
	tmmediate Cause (Final	1	, ,	L							
П	disease or condition resulting in death)	/19	malin	me	win	e					
_	rosoning in dozini,	111	Due to (or as a or	insequence	e of):						
Examine		Kis	Piralm	du	SUFT	ziem	4			1	
E	Sequentielly list conditions.	0.	Due to (or es a co	onsequence	a of):	7 -1 -1	1				
TX.	if any, leeding to immediate cause. Enter Underlying	CHE.	2				1			i	
60	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants	C	Due to for on a co		n of):					-	
edical	resulting in deeth) Last		Due to (or es a co	nsequence	e or):						
N.		d									
200	Part II. Other significant conditions	contributing to death	but not resulting in	the underly	ing cause	given in Pert	1.	23b. Did	tobacco use co	entribute to the	cause of death'
-01E				51,1				10	Yes 2 No	3 Probab	ly 4 Unknow
١									20,10		
4											
2								242 Was	an autonsy	24b. Were	autopsy findings
P									an autopsy ormed?	evailal	autopsy findings ble prior to letion of cause
D										evailal	ble prior to letion of cause
D								perfe		evailal compt of dea	ble prior to letion of cause
Completed by	25. Was case referred to medical					as Bloo	on of Death	perfe	Yes 2 No	evailal compt of dea	ble prior to letion of cause th?
be completed by	25. Was case referred to medical examiner?	Hospital:				Whor:		1 (Check only	Yes 2 No	evailal compt of dea	ble prior to letion of cause th?
To Be Completed by Physicia	examiner? 1 ☐ Yes 2 M No	Hospital: 1 ☐ Inpat			LOOA	Other: 4 N	lursing Hon	1 (Check only	Yes 2 No one)	evailal complied dea 1 1 Your (Specify)	ble prior to letion of cause th?
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edical Certification: To be Completed by	examiner?  1 Yes 2 No  27. Menner of Deeth  1 Naturel 2 Accident 3 Suicide 4 Homicide  29a. Certifier  2 Certifying F	28a. Dete of ini (Month, D on be d 28e. Placa of in building, e	ury 28b. Ti ey Year) 28b. Ti fin hjury - At home, fam tc. (Specify) of my knowledge, of examination and	me of jury Mm, street, for deeth occur	28c. fn W 1 1 ectory, office	Other: 4 N	No 2	Check only  (Check only  ne 5 Res  8d. Describe  18f. Location City or To	Yes 2 No one)  Idence 8 Ott how injury occu  (Street end Num wn, Stete)	evailation complete c	ble prior to letton of cause th?  es 2 No  oute Number,
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DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** CAROLEE KOENIG LIST November 23,2000 12:05 AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Timonium Baltimore County Stella Maris Hospice If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months 1 M 2 N F 212-30-3055 69 Director Aug 18, 1931 Maryland Usual Residence of Decedent with the Meryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rai", or items 23s or 28s-f show Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1606 Greenspring Drive 21093 USA Funeral 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced be filed within 72 houtal Hygiene.
d other than "nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence of Health end Mental Hy 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Henry Koenig Frieda Edna Nizer 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Mr. C. William List (Husband) 1606 Greenspring Drive, Lutherville, Maryland Baitimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I permit. Pages Department of important: If It any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 11/25/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Martin D. Lawson Xausin Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Approximate Approximate 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not eshock, or heart failure. List only one cause on each line. Interval Bety Onset and Death Physician /Medical Immediate Cause (Final * PANCREATIC CANCER disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): and attending physician for use as the hune 68760 Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.0. 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 X Unknown 3 of Vital Records, Completed by 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 Yes 2 No 1 ☐ Yes 2 No or Attanding Physician: 25. Was cese referred to medical exeminer? Be 28. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Division Injury 1 Natural 2 Accident 5 Pending death, 1 Yes 2 No investigation Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled it 150 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) 29a. Certifier Medical (Check only one) end manner steted. 29b. Signeture and title of an Hijer 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month, Day, Year)

NOV 2 7

12:10

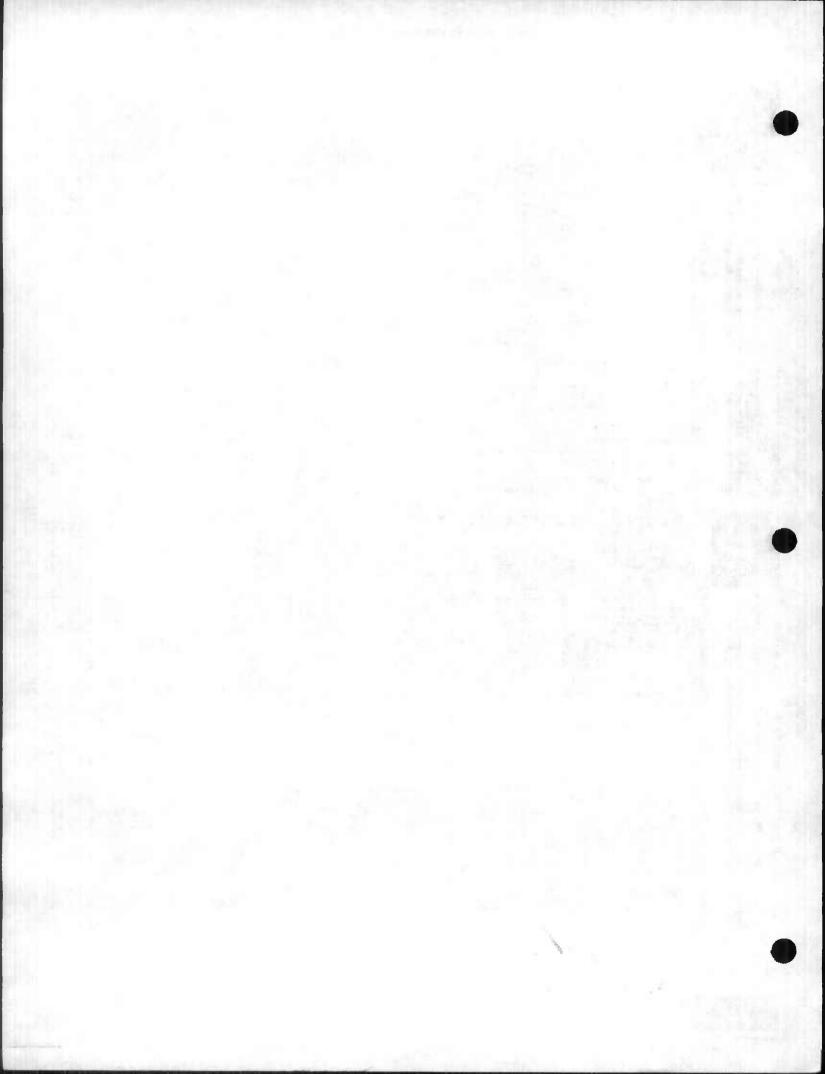
2000

23,

NOVEMBER

CAROLEE LIST

32. Registrer's Signeture



Facility Name (First, Middle, Last)  Levindale Geriatric Certain BALTO  ocial Security Number  103 Yrs. State  10b. County  MD N/A  BELVEDERE AVENUE  12 Was Decedent Ever in U,S.  Amed Forces?  13 Was Decedent of Hispanic Origin? (S. Amed Forces?)  13 Was Decedent of Hispanic Origin? (S. Amed Forces?)	8. Date of Birth (Month, Dey, Y FEB.18,		Death  N/A  Birthplace (State or Foreign MD)  10d. Inside City Limit  1 X Yes 2 N  t Country?			
Levindate Ceriatric Center BALTO cocial Security Number  212-12-7689  103  103  100. City, Town or Location  BALTIMORE  Street and Number  2434 W. BELVEDERE AVENUE  BALTO RAGE (In yrs. last birthdey)  MO Days  H Under 1 Year  H Under 1 Year  H Under 1 Year  H Under 24 Hrs.  Min.  10c. City, Town or Location  BALTIMORE  10f. Zip Code	S. Date of Birth (Month, Dey, Y FEB . 18,	4c. County of E  4c. County of E  (ear)  9.  1897	Death  N/A  Birthplace (State or Foreign MD)  10d. Inside City Limit  1 X Yes 2 N  t Country?			
According to Certatric Center BALTO  Docial Security Number  6. Sex. 1212-12-7689  103 Yrs. Months Days Hours Min.  104 Proceeding State 106 County MD N/A BALTIMORE  Street and Number 107. Zip Code  2434 W. BELVEDERE AVENUE 21215	8. Date of Birth (Month, Dey, Y FEB.18,	1897 9. Citizen of What	N/A Birthplace (State or Foreign Country) MD  10d. Inside City Limit 1 2 Yes 2 N t Country?			
cotal Security Number 212-12-7689	FEB.18,	D. Citizen of What	Birthplace (State or Foreign Country)  MD  10d. Inside City Limit  1 X Yes 2 N  t Country?			
212-12-7689	FEB.18,	D. Citizen of What	MD  10d. Inside City Limit 1 X Yes 2 □ N t Country?			
State         10b. County         10c. City, Town or Location           MD         N/A         BALTIMORE           Street and Number         10f. Zip Code           2434 W. BELVEDERE AVENUE         21215	5	U.S.A	1 X Yes 2 □ N t Country?			
MD N/A BALTIMORE  Street and Number 109. Zip Code  2434 W. BELVEDERE AVENUE 21215	5	U.S.A	1 X Yes 2 □ N t Country?			
Street and Number  2434 W. BELVEDERE AVENUE  10f. Zip Code  21215	5	U.S.A	t Country?			
2434 W. BELVEDERE AVENUE 21215	5	U.S.A	•			
Meritel Stetus 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Hace - /				
Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give 1 ☐ Yes 2 🟋 No Specify: Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					
15. Decedent's Education 16a. Decedent's Usual Occupation		b. Kind of Busine	ess/Industry			
(Specify only highest grede completed)  Give kind of work done during most of work  iffe. DO NOT use retired)  College (1-4or 5+)	king					
12 SALESMAN		SHOES				
	ne (First, Middle, Ma	iden Sumeme)				
EDWARD LEBOVWITCH FANNI	E		VEX			
Informant's Name/Reletionship (Type, Print)  19b. Mailing Address (Street end Number or Ru	irel Route Number, C	City or Town, Ste	te, Zip Code)			
MARSHA SINDLER / DAUGHTER 3203 OLD POST DRIVE #						
Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete  4 ☐ Donation 5 ☐ Other (Specify)  ANSHE EMUNAH (AITZ CHAIM)	11/22/00	BALTIM	y or Town, State  ORE, MD			
Signature of Funeral Service Licenses 22. Name and Address of Fecility SC	L LEVINSO	N & BROS	S., INC.			
1/1/W/47/1/ac/ 8900 REISTERSTOWN						
Party. Enter the disease, or domplications that ceused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one place on each line.	or respiratory erres	it,	Approximate Interval Between Onset and Death			
ediate Cause (Final ese or condition liting in death)  a. Conjestive Heart Fair	live		years			
Due to (or as a consequence of):  Atheroselente Cardioruscula	r Disco	we	years			
uentially list conditions, p, leading to immediate e. Enter Underlying so (Disease or Injury						
c						

**Physician** /Medical **Examiner** 

> Medical Certification: To Be Completed by Physician/Medical Examiner Sequentially list condit if any, leading to imme-cause. Enter Underlyi Cause (Disease or Inju-that initiated events resulting in death) Les

23a Bart V. Enter the shock, or heart

Immediate Cause (Fir disease or condition resulting in death)

1. Decedent's Name

4a Facility Name (If n

Levina 5. Social Security Num

Usual Residence of D

MD 10e. Street and Numb 2434 W

11. Meritel Stetus 1 Never Married

(Specify Elementary/Second 17. Father's Name (Fit **EDWARD** 19a. Informant's Nam MARSHA 20a. Method of Dispos

10a. State

**Physician** /Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglens. Important: If Itam 27 is marked other than "natural", or frame 23s or 28s-f show any injury or other traumatic avent, the Medical Examinar must be notified at each

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Vinary Bl	ontributing to death but not re-		g cause given in Part 1.	relikras-filorakori	23b. Did tobecco use co	ntribute to the cause of death?  3 Probably 4 Unknown			
Dementia					24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?  1  Yes 2 No			
25. Was case referred to medical			26. Place	of Deeth (	Check only one)				
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐	DOA Other: 4 Nu	rsing Home	5 Residence 6 Oth	ner (Specify)			
27. Menner of Deeth  1 Matural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe how injury occurred				
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, ferm, street, fac ify)	tory, office	28	f. Location (Street end Numb City or Town, Stete)	ber or Rurel Route Number,			
	ysician: To the best of my known the control of the basis of examine and manner stated.								
29b. Signature and tille of certifier	m. Dys	2	29c. License number D339	43	29d. Date, signe	(Month, Day, Year)			

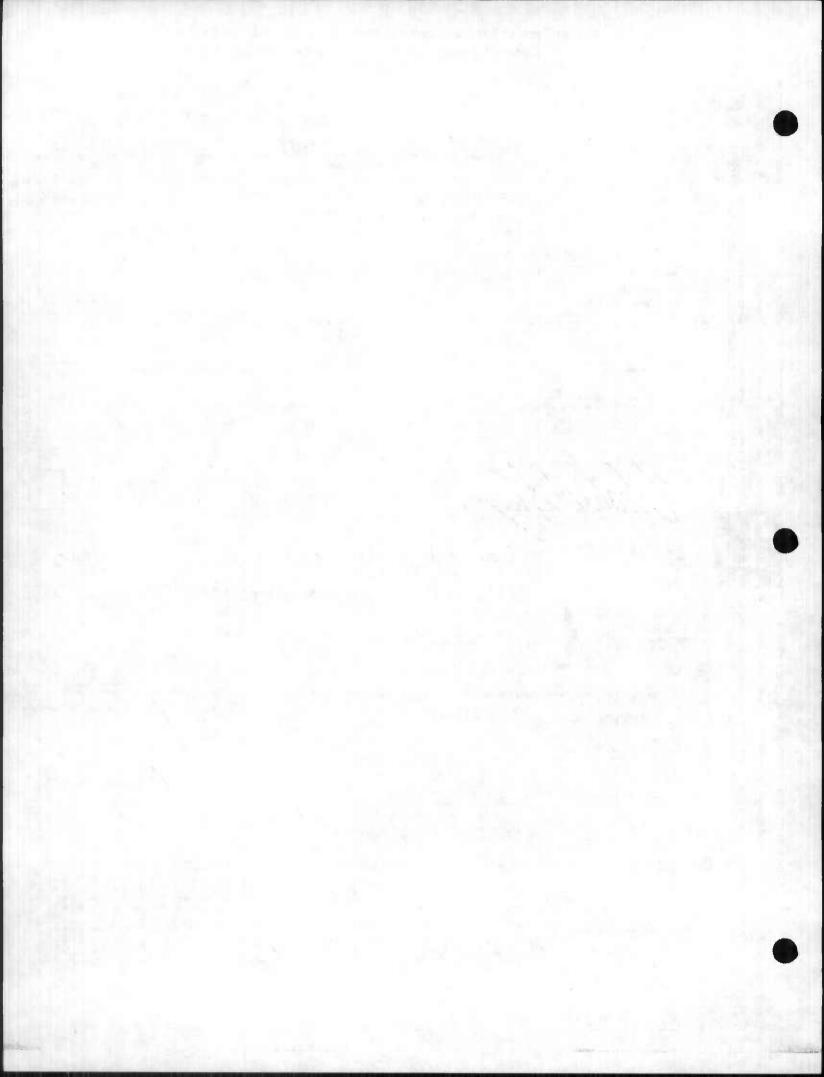
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the bunal-transit Division of Vital Records, P.O. Box 68760,

> State Registrar

31. Dete filed (Month, Dey, Year) NOV 2

30. Nemed and address of person who completed ceuse of death (Item 23e) (Type, Print) 32. Registrer's Signeture

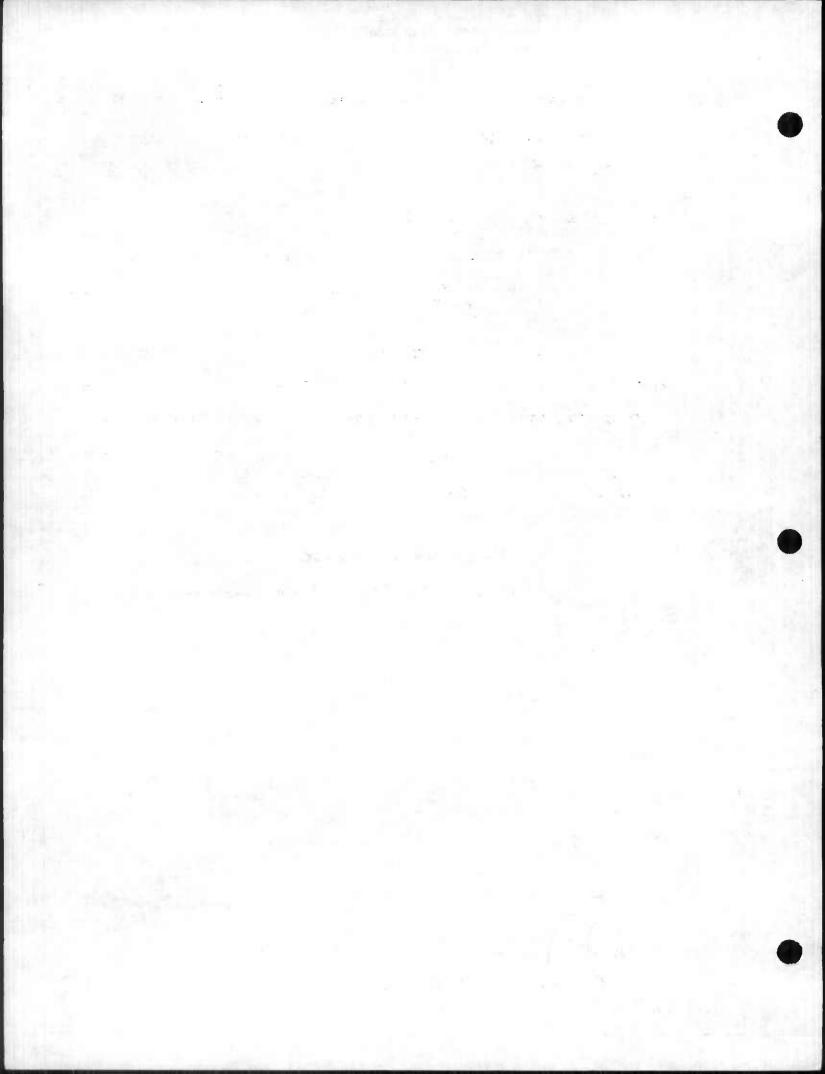


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg, No.

		1. Decedent's Na	me (First, Middla, Las	it)		197				2. Data of Deat			3. Tima of Death
Physic /Medi			WALLAC	Е			LOND	ON	N	OVEMBER	20, 2	000	5:30PM
Exami	_	4a Facility Nama	(If not institution, give	street and number	r)			4b. City, To	own, or Loca	ation of Death	4c. County	of Death	
			LD COURT F						TIMOR			IMORI	
Funeral Director		5. Social Security 212–16–	·9110 ¹	9X 7. A	lga (In yrs. li 82	ast birthday) Yrs.	Months D	ays Hours	Min.	B. Data of Birth (Month, Day, JAN.17	Year) 1918	9. Births	place (State or Foreign htry) MD
pue k		Usuel Residence	of Decedenf 10b. County		10c. City	, Town or Lo	ocation					1	Od. Inside City Limits
with the Maryland a or 28a-f show	tor	MD	BALTIM	ORE		BALTIN							1 ☐ Yas 2 💢 No
ith the M or 28a-f	Director	10e. Street and N	umber				10f. Zip Co	da		1	0g. Citizen of \	What Cou	ntry?
th wit		4001 0	LD COURT F	ROAD #204				212	208		U.S.A		
affer deeth or Herne 23	Funerai	11. Merital Status	rried 210 Married	12. Was Dacedan Armed Forcas 1 X Yas 2 L If Yes, Giva	?	S. 13.		of Hispanic Or Cuban, Maxica No Specify		ify Yes or No- ican, atc.)	Btac	ck, White,	
5-0036 72 hours after	d by	3 Widowed	4 Divorced	Yaar or Datas	AIR FO	DRCE					Specify		HITE
15-1 17-1 10-1	Completed		15. Decedent's Ed ecify only highest gra-			(Giva	dent's Usuat O kind of work d DO NOT usa re	one during mo	st of working	9	16b. Kind of B	usinass/in	dustry
Maryland 2121. d 2 should be filed within th and Mental Hygiene. T is marked other than "T taumatic event, the Mental Hygiene"	ошо	Elementary/Sec		Collega (1-4or			OPERAT				MANUF	ACTUE	RED LUGGAGE
be filed that Hyging dother	BeC	17. Fether's Name	(First, Middla, Last)			07121217	Oz Esta 12		er's Name (	(First, Middle, I			CDD BOOGHOL
Taryland 2 should be filed and Mental Hygin is marked other aumatic avent,	To	DAVID				LONDON	J	BESS	SIE			GL	ASSNER
Aaryla 2 should and Mer is marke			Name/Ralationship (7			100				Route Number			
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Pegenent on ment o		1X Buriai 2	Cramation 3 5		CE	matary, crai	natory or othai	r place)	TERY 1	1/22/00			rown, MD
Baltime permit. Peg Department Important: any Injury o		21. Signature of F	junarel Sarvice Licen	Sea City	Pla			ddress of Facil	5				S., INC. MD 21208
		23e. Per(1. Entar	tha disaasa, or comp art failura. List only	olications that cause	ed the death								Approximate Intervel Between
Physician		3110011, 01 110	and ramora. Electionly	,	iii lo.								Onsat and Death
/Medical Examiner		Immediate Ceuse disaasa or condit rasulting in death	(Final ion	a. Re,	pira	Lorg	enr	ext					
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of the d	Examiner	On a single state of the single state of		b. Met	Duestolor	as a conse	hy ru	id co	zncu	none	•	i	
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octificate be execut ding physician and	an/Medical	Cause (Disease of that initieted evan rasulting in death	TS T	C	Due to (or	es e consec	juence of):						
ortifica	Mec			d									
₩ € % Z				0									
P.O. that the de detached detached	Physic	Part II. Other sign	ificant conditions co	entributing to death	but nof rasu	lting in the u	nderlying caus	a given in Part	1.				o the cause of death?
S, P	Y P									1 T	2 2000	3 Pro	bably 4 Unknown
Division of Vital Records, P.O. E or Attanding Physician: The law requires that the deal after death. Director: After this certificate has been signed by the att in by the funeral director, page 2 should be detached to	Completed by									24a. Was a perform	n autopsy ned?	av C	ara autopsy findings vailable prior to empletion of cause death?
I Re	dmo									1 Y	as 20240		☐ Yas 2☐ No
Vital I	Be C	25. Was case refe	erred to medicat					26. Plac	e of Death	(Check only or			_ 143
yalcla yalcla is cent	ToB	axaminar?	No	Hospital:	tiant 2 🗆 I	ER/Outpetie	nt 3 DOA	Other		e 5 🔀 Raside		ner (Speci	ty)
Vision of Vita Attending Physician: or death. ector: After this certific by the funeral director.		27. Manner of Dec	ath 5 ☐ Panding invastigation	28a. Data of tn (Month, D	jury Jay Year)	28b. Time o Injury	f 28c.	Injury at Work? 1 Yas 2		8d. Dascribe h	ow injury occur	red	
Division or Attendiate death Director: A d in by the f	ertifica	3 ☐ Suicide 4 ☐ Homicida	6 Could not be datarmined	280. Placa of I	njury - At ho etc. (Specify	ma, farm, st	reat, factory, of	ffica	21	8f. Location (S City or Town	treet and Numi n, Stata)	ber or Rur	al Routa Number,
Hospita 24 hours Funeral Neily filled	edicai Certification:	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	rsician: To the besiner: On the basis and menners	of examinati	vledge, daat ion <i>e</i> nd/or in	h occurred at ti vestigation, in	he time, data a my opinion, da	nd place, areath occurred	nd dua to the c d at tha tima, d	ause(s) and mate and place,	anner as :	stated. to the cause(s)
vithin 2 To the comple	Me	29b. Signefura an	d title of certifiar	and morniar s	stateu.		29c. Li	icense number		2	9d. Date signe	d (Month,	Day, Year)
F S F O		<b> //</b>	1				10	19914			11/2	100	
		30. Nama and add	tress of person who c	completed causa of	daath (Item	23a) (Type,			1112		. ,	, , ,	
7		IraT	Finedo	10753	FU	2 hol	Lul	Levill.	e Ma	1210	(9)		
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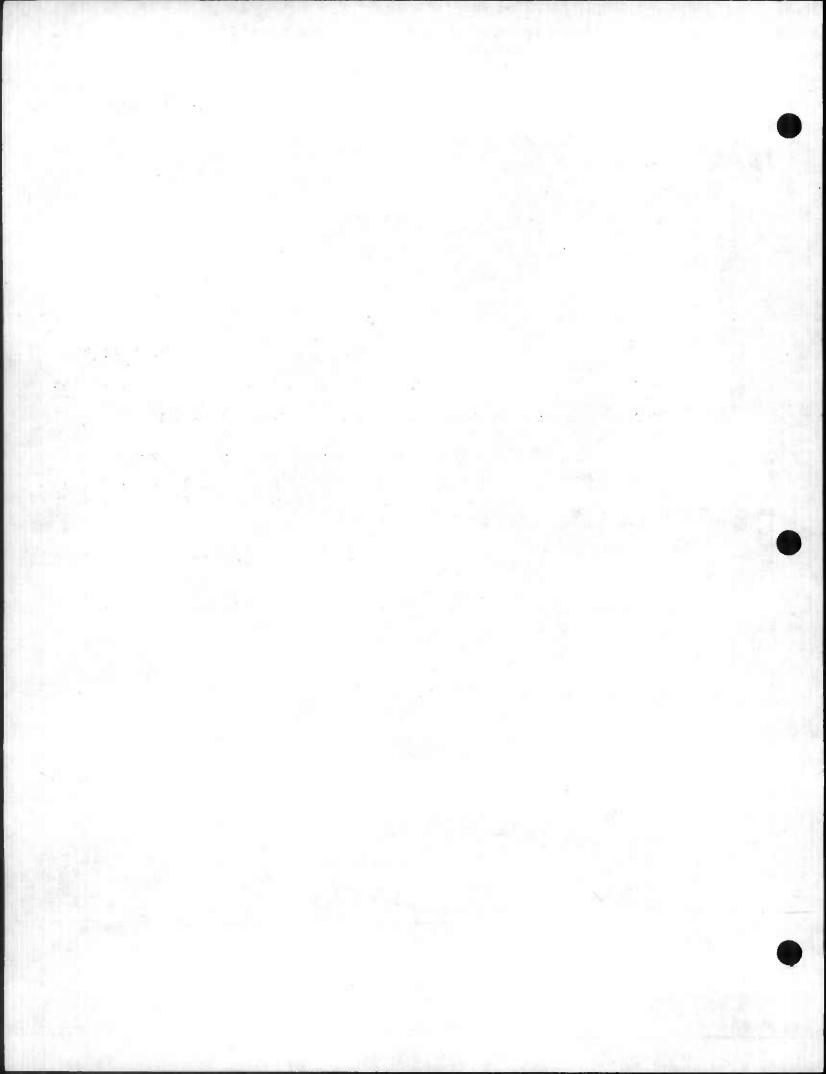
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 22, 2000 NATALIE LEON NOVEMBER 8:58 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 12 WILD CHERRY COURT REISTERSTOWN BALTIMORE 5. Social Security Number 218–40–0745 If Under 1 Year 8. Date of Birth (Month, Day, Year) DEC . 2, 1942 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗙 F 57 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 WILD CHERRY COURT 21136 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry filed within Elementery/Secondary (0-12) College (1-4or 5+) SECRETARY SINAI HOSPITAL Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 88 should be and Mental is marked HARRY LEON T.TT.T.TAN F. SCHEINBERG 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 at Department of Health and Important: If them 27 is n ROCHELLE SHEVITZ / SISTER 2108 OUR LANE - STEVENSON, MD 21153 Saltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/00 BETH TFILOH CEMETERY WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solvica License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD — PIX
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 1 0 O Cest Examiner Due to (or as a consequence of) Examiner The lew requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of): ed by the a P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by I should be detect 1 Yea 2 No 3 Probably 4 Unknown Division of Vitai Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has page 1 Yes 2 DN 1 Yes 27100 or Attending Physician: 25. Was case referred to medicel director, Be 26. Place of Deeth (Check only the) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home P 1 Yes 2 No 5 Pasidence 6 □Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of Injury tnjury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigetion 1 Yes 2 AND eral Director: A death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) aftar 4 | Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai completaly (Check only one) Ma. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 00 ans 30. Name and address of person who Se S. Sepice no completed cause of deeth (Item 23a) (Type, Phit) Mills OWINGS 0 Painters Mill Rd, Ste 135, 90 Margolis. NOV 2 7 2000 32. Registrar's Signature

Registrar

DHMH 16 Rev 6/95

2 Becker **ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene U 372

Division of Vital Records.

RUTH.

certificate has b lirector, page 2 s After this funarel of or Attanding Parties of the Attacker | At the in by

To the Hospital o within 24 hours af To the Funeral Di completely filled is

State

Registra

Be

To

Certification:

5 Pending invastigation

6 Could not be

MT

28e. Dete of Injury (Month, Day Year)

29c. License number 251596

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and menner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) NOVEMBER 21 St 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2KLNo

1 ☐ Yes 2 ☑ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Hospitel:

TIG MAIDEN CHOICE LANE, CATONSVILLE, MD 21228 K. AMBALAVANAR

1)☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

28b. Time of

NOV 2 7 2000

29b. Signeture and title of certifier

25. Wes case referred to medicel exeminer?

1 ☐ Yes 2 ☑ No

27. Menner of Death

1 Neturel

2 Accident

3 ☐ Suicide

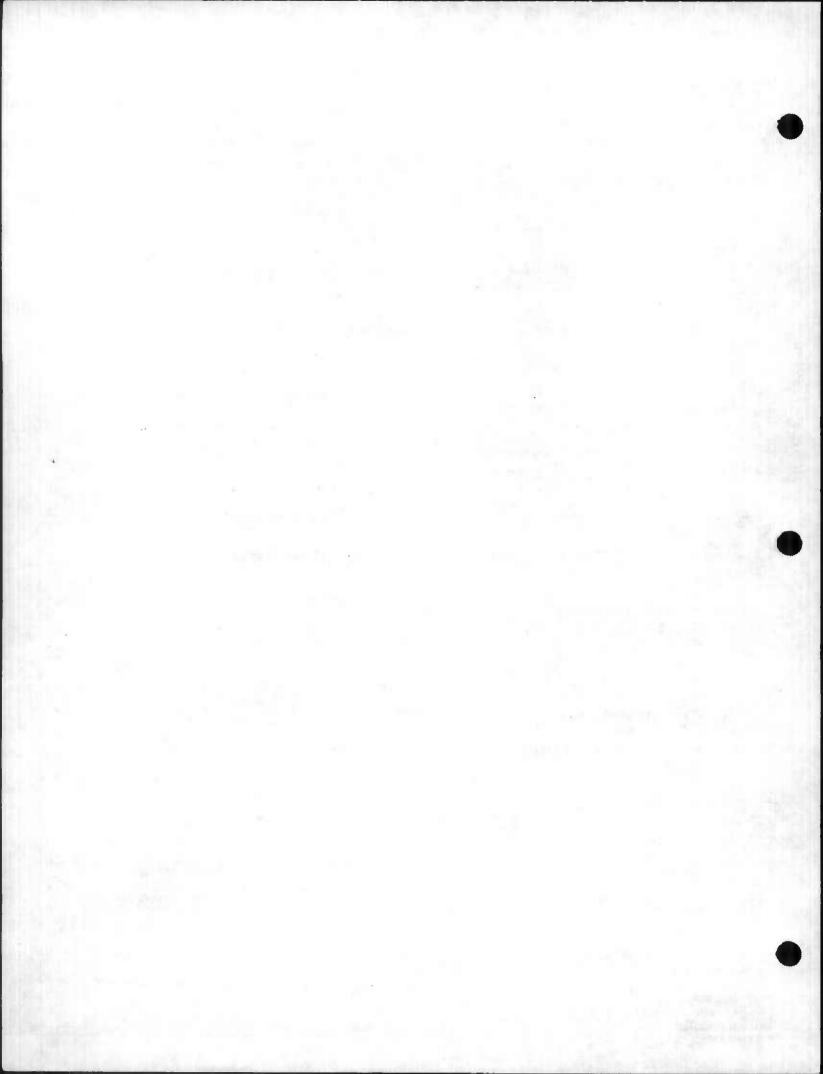
29a. Certifier

4 ☐ Homicide

(Check only one)

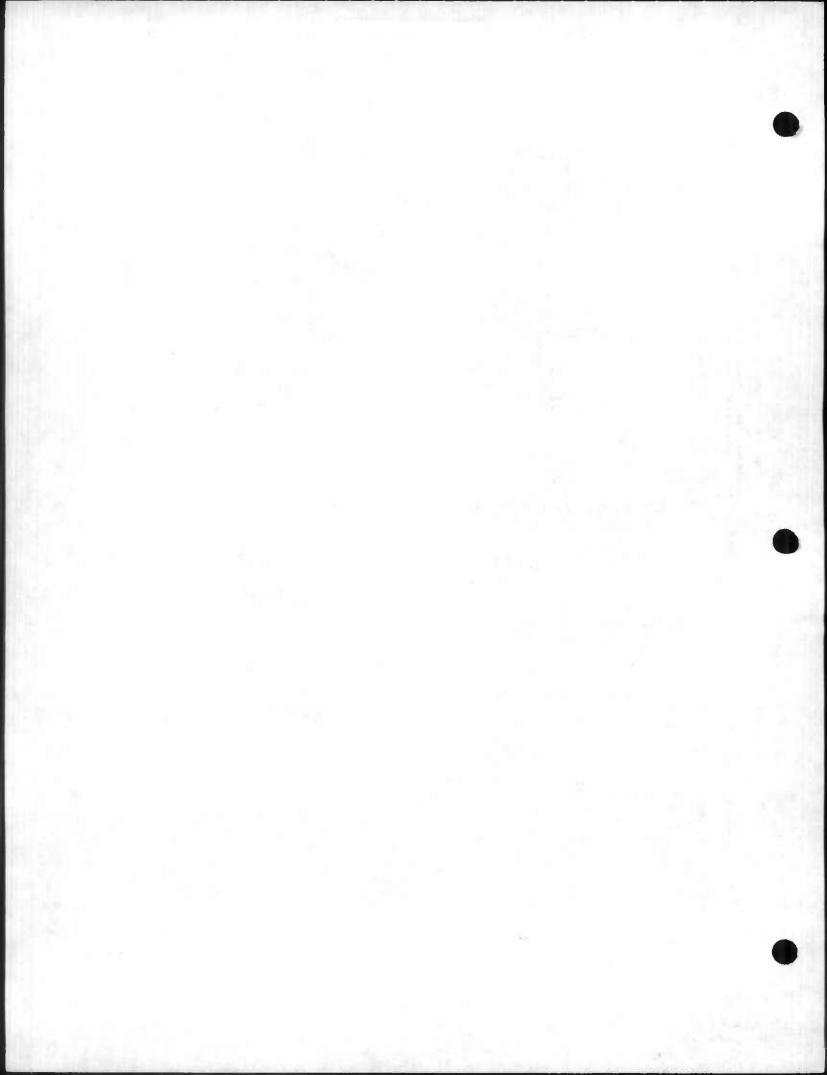
32. Registrar's Signetura

ORIGINAL



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37283

				Certifica	ate of	Death	Reg	J. No.		
	1. Decedent's Nama (First, Middle,	Last)	F H Z				2. Dete of Deeth Month	Dev	Yeer	3. Time of Death
Physician /Medical	VIRGINIA	JANE MO	CK				November		.000	2:50 P.M.
Examiner	An English, Mama /// and Inglitudian	give street and number)				4b. City, Town, or Lo	cation of Death	4c. County	of Deeth	
	1121 Bellemore	Road				Baltimor	e	N/	Α	
Funeral		6. Sex 7. Ag	ge (In yrs. last bi	Month	s Deys	If Under 24 Hrs. Hours   Min.	8. Dete of Birth (Month, Dey, )	(ear)	Coun	lace (Stete or Foreign
Director	176-30-7779		64	Yrs.			June 26,	1936	Penn	sylvania
pue	Usual Rasidence of Decedant  10a. Stete 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limits
Aaryl		A	Balti							11☑ Yes 2 □ No
vith the Ma	10e. Street and Number		Dazoz		Zip Code		100	. Citizen of V	Vhat Coun	try?
uth with the Manylar 23a or 28a-f show ant be nounted at	1121 Bellemore	Pond				1210		1000	5.A.	
offer death vilour from 234	11. Merital Status	12. Was Decedent	Evar in U.S.	13. Was Dec			ecify Yes or No-		o - Americ	en fndien,
or frame	1 Nevar Married 2 Marrie	Armed Forces?				lispanic Origin? (Speen, Mexican, Puerto	Rican, etc.)	Blac	k, White,	etc.
21215-0020 d within 72 hours aff plane. r than "natural", or the first factor controlled by F		If Yes, Give Yeer or Detes:		1 ☐ Yes	2₩ No	Specify:		Specify	Whi	te
1215-0020 within 72 hours after death with the Maryland ane. then "natural", or flama 23s or 28e-f show the Maryland and Maryland	15. Decedeni'		16a	. Decedent's Us	suel Occup	petion	. 16	6b. Kind of Bu	siness/Ind	dustry
21215-0 ed within 72 ho ygiene. nor than "neturi it, the May call to modeled	(Specify only highest Elementery/Secondery (0-12)	College (1-4or	5+)	life. DO NOT	use retire	duning most of work d)	ng			
id 212 filed within Hygiene. without them end, the Head of the Hea		4 years		Homer	naker			Own	Home	
and 2 be filed tal Hygie d other, if	17. Fether's Name (First, Middle, L	ast)				18. Mother's Name	(First, Middla, Ma	aiden Surnam	a)	
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event	Charles Chalf	ant Shenk				Marion		C:	laus	
Aar 2 sh and is m	19e. Informent's Neme/Reletionsh	lp (Type, Print)	198	o. Meiling Addre	ess (Street	end Number or Run	al Route Number,	City or Town,	State, Zip	Code)
2 2 8 2 7	David G.F. Mock	(husband		121 Bel		e Road B	altimore			
Baltimore, semit. Pages 1 separtiment of He mportant: If Hem my Injury or other and in	20e. Method of Disposition 1 □ Burial 2 □ Cremetion	3 □Ramovel from Stata	camete	of Disposition (A ary, cremetory o	r other ple	ce)	Dete 20	Oc. Location -	City or 10	wn, Stete
ultim nit. Pag arment ortant: b Injury o	4 Donetion 5 Other (Sp	ecify)		Mount	Crema	atory 11	-27-00 B	Baltimo	re, l	Maryland
Baltim permit. Par Department Important: any Injury	21. Signeture of Funaral Service L	icensee		Mitch	end Addre	viedefeld	Funeral	Home	Tnc	
m goesa	Gerral	herran	-			Road Ba				21212
	23a. Pert1. Enter the disease, or a shock, or heert failure. List of	complications that cause	d tha daath. Do	nol enter tha m	ode of dyir	ng, such es cardiac	or raspiratory erres	it,		Approximate Intervel Between
Physician	CALL THE STATE OF				1		,			Onset and Deeth
/Medical - Examiner	Immediate Cause (Final disaase or condition	leen	a Cou	cer -	met	astac	to hea	uu.		
	resulting in deeth)		Due to (or es e	consequence o	ol):	20			1	
n and said saidsaning		b	3	Leur	به د	nd leey	0		1	
and little	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or es e	consequence o	of):	1				
		С							i	
licate be liphysical at the bu	that initiated events resulting in death) Last		Dua to (or as a	consequenca o	f):				1	
		d								
Box nath car tor use										
at the death certain the death certain distribution of the strendin etached for use	Pert II. Other significant condition	e contributing to death b	out not resulting i	in the underlying	g cause gh	ven in Part I.				the causa of death?
							1 VY0	8 2∐ No	3 Pro	bably 4 Unknow
rdS,							24e. Wes an	eutonev	24b. W	ere eutopsy findings
The law require the law require has been a page 2 should Completed							perform	ed?	av	allable prior to impletion of cause
The star								_/		déath?
ti The title h		``					1 🗆 Yes	2 No	1[	☐ Yes 2☐ No
VITAI RECORDS, siden: The law requires it certificate has been signe rector, page 2 should be be Completed by		Hospitel:			Oil	har	h (Check only one			
F 4 4 F		1 ☐ fnpati		Time of	DOA 28c. Inju	4 LI Nursing no	me 5 Resident			(y)
E 2 22 C	1 Naturel 5 Pending	(Month, Da		fnjury	Wo	rk?  Yes 2□No	200. Describe nov	winjury coods		
D 8244 E		nt he	iuny - At home fo			7.00 2.3.10	28f. Location (Stre	eet end Numb	er or Run	al Route Number
thends death. death. y the h	2 Accident Investig	28e Plece of In		oiiii, oiioot, iuoi	ory, onice		City or Town,	State)		
DIVISION or Attending sther death. Director: Afte i'n by the tune ertification	3 Suicide 6 Could n 4 Homicide determine	28e. Plece of In building, et	(							
事式通信 O		ned 288. Place of in building, el		a death accurr	ad at the ti	me date and place	and due to the cau	seals) and me	200000000000000000000000000000000000000	teled
Hospita 24 hours Funeral day filler IICal C		Physician: To the besi caminer: On the besis of	of my knowledg	e, deeth occurre	ed et the ti	me, dete end plece, opinion, deeth occur	end due to the ceu red et the time, det	use(s) end me le end plece,	enner es s and due to	tated. o the cause(s)
the Hospita hin 24 hours the Funeral npletely fille	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best	of my knowledg	nd/or Investigati	ed et the ti on, in my o	opinion, deeth occur	red et the time, det	use(s) end me te end plece, d. Date signe	and due to	the cause(s)
he Hospita in 24 hours he Funeral pletely fille edical C	29a. Certifier 1. ☐ Certifying (Check only one)	Physician: To the besi caminer: On the besis of	of my knowledg	nd/or Investigati	on, in my o	opinion, deeth occur	red et the time, det	te end plece,	and due to	the cause(s)
the Hospita hin 24 hours the Funeral npletely fille	29a. Certifier (Check only one)  29b. Signeture and titla of certifier	Physician: To the best examiner: On the bests on and manner st	of my knowledgy of exemination and eted.	nd/or Investigati	on, in my o	opinion, deeth occur se number	red et the time, del	d. Date signe	d (Month,	Dey, Year)
the Hospita hin 24 hours the Funeral npletely fille	29a. Certifier 1. ☐ Certifying (Check only one)	Physician: To the best examiner: On the bests on and manner st	of my knowledgy of exemination and eted.	nd/or Investigati	on, in my o	opinion, deeth occur se number	red et the time, del	d. Date signe	d (Month,	Dey, Year)
the Hospi hin 24 hou the Funer npletely fit	29a. Certifier (Check only one)  29b. Signeture and titla of certifier  29b. Name and eddress of person was a constant.	Physician: To the best xaminer: On the bests of and manner st.	of my knowledgy of exemination and eted.	nd/or Investigati	on, in my o	opinion, deeth occur se number	red et the time, del	d. Date signe	d (Month,	the cause(s)



Baitimore, Maryland 21215-0036

Please	Type or Print								ble.		
	State of Mar	-		rtment of l tificate of				giene	3	728	34
1. Decedent'a Name (First, Middle, La	ast)		1115	TI TIPIT!	PIFF		2. Date of Dear Month		Year	3. Time	of Death
Doris Chlada Mille	er						Noveml	ber 19	,200	00 12	2:15pm
4a Facility Name (If not institution, gh	ve street end number)				4b. City, To	wn, or Le	ocation of Death	1			
Greater Balti	more Medi	cal Ce	ont e	or	Tows	an		Balt	· i mo 1	~ ~	- 5
5. Social Security Number 6. S 220 22 5906		(In yrs. lest birtl	thday)	If Under 1 Year Months Deys	ar   If Under a	24 Hrs. Min.	8. Date of Birth Month Dey July 29 1	h	9. Birth	place (Stet	city,MD
Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Locr	ation						10d. Inside	City Limits
Maryland Baltimore		Timonium									es 2QNo
10e. Street and Number		Шиши		10f. Zip Code				10g. Citizen of V	What Cou	intrv?	^
				21093			19 1	USA	Primar Co.	may.	
227 Deep Dale Drive	12. Was Decedent Ev	ver in U.S.	13. W		Hispanic Or	igin? (Sr	pecify Yes or No-		ce - Ameri	ican Indien.	
1 Never Married 2 Married	Armed Forces?			Yes, specify Cul					ck, White,		
3 XWidowed 4 Divorced	If Yes, Give Yeer or Dates:		10	☐ Yes 21☐ No	o Specify:			Specify	y:White	3	
15. Decedent's E (Specify only highest gra		16a.	(Give kil	ent's Usuel Occu	e during most	t of work	king	16b. Kind of B	usiness/in	ndustry	
Elementary/Secondary (0-12)	College (1-4or 5+)	)	'life. DC Sewife	O NOT use retin	ed)			Housekee	oing-(	Own Hon	ne
17. Father's Name (First, Middle, Last			70		18. Mothe	er's Nam	e (First, Middle, I			J1	
James Walter Lockard					Berdie	e Sum	mers				
19a. tnformant's Name/Relationship	(Type, Print)	19b	. Mailing	Address (Stre			rel Route Number	r, City or Town	Stete, Zi	ip Code)	
John Chlada (Son)		54.5	57 E	Mithedal	e Drive	Sal	isbury, Me	aryland 2	1801		U - Back
20a. Method of Disposition		20b. Place of	Disposit	ition (Neme of etory or other pl				20c. Location -	-	own, Stete	
1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci			d Cem	n. Novemb	ber 24,2		F	Baltimore	, Mary	yland	
21. Signature of Funeral Service Lice	oho Chor	ocki	Las	Name and Addr Ssahn Fund Ol Belair	eral Hor	ne Inc	c ore, Marvl	land 2123	36		
23a. Part1. Enter the disease, or com shock, or heart tailure. List only	nplications that ceused the	a daath. Do n								Approxim Interval E Onset an	Between
Immediate Cause (Final disease or condition resulting in death)	a. Septic	= SHO	CK				15	THE			
	EN TO	ue to (or as a c	onseque	ence of):					i		
	D			e SG	TICE	nin	2		i	-	
Sequentially list conditions, if any, leeding to immediate		ue to (or es a c							†		
ceuse. Enter Underlying Cause (Disease or Injury	C. INTRA				CEES			MICAL.	i		
that initieted events resulting in death) Last	DIVERT	ie to (or as e c	onseque	ance of):							- 1
	DIVERT	ICULO	515								
					101						
Pert II. Other eignificant conditions						i.	1000	lobacco uee co	1 /		
TYPE I DINGG	ne, PUL	MONA	M	FIBRO	212		1 D Y	Yes 2 No	3 □ Pro	obably 4	Unknown
Congest	IVE HEAR	I FA	LUL	CE				as an autopsy dormed?  24b. Were autopsy available prior completion of of death?			or to
							101	Yes 2 No	1	☐Yes 2	BNo
25. Was case reterred to medicel					26. Plac	e ot Dea	th (Check only or	ine)			
examiner?	Hospital:	t 2 ER/Out	tpatient	3□ DOA C	Other:		ome 5 Resid		her (Spec	city)	100

**Physician** /Medical Examiner

Physician/Medical Examiner

Completed by

edical Certification: To Be

Funeral Directo

Be Completed by

**Physician** 

/Medical

Examiner

**Funeral** Director

permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Emmine must be notified at page.

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and expupletely filled in by the luneral director, page 2 should be detached for use as the burial-trensit Division of Vital Records, P.O. Box 68760,

25. Was case examiner 1 Yes 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? NA 5 Pending investigation NA М 1∏Yes 2□No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide NA

29a. Certifier (Check only one)

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

21234

- Nolan us

NEAR REES

525010

11/19/00

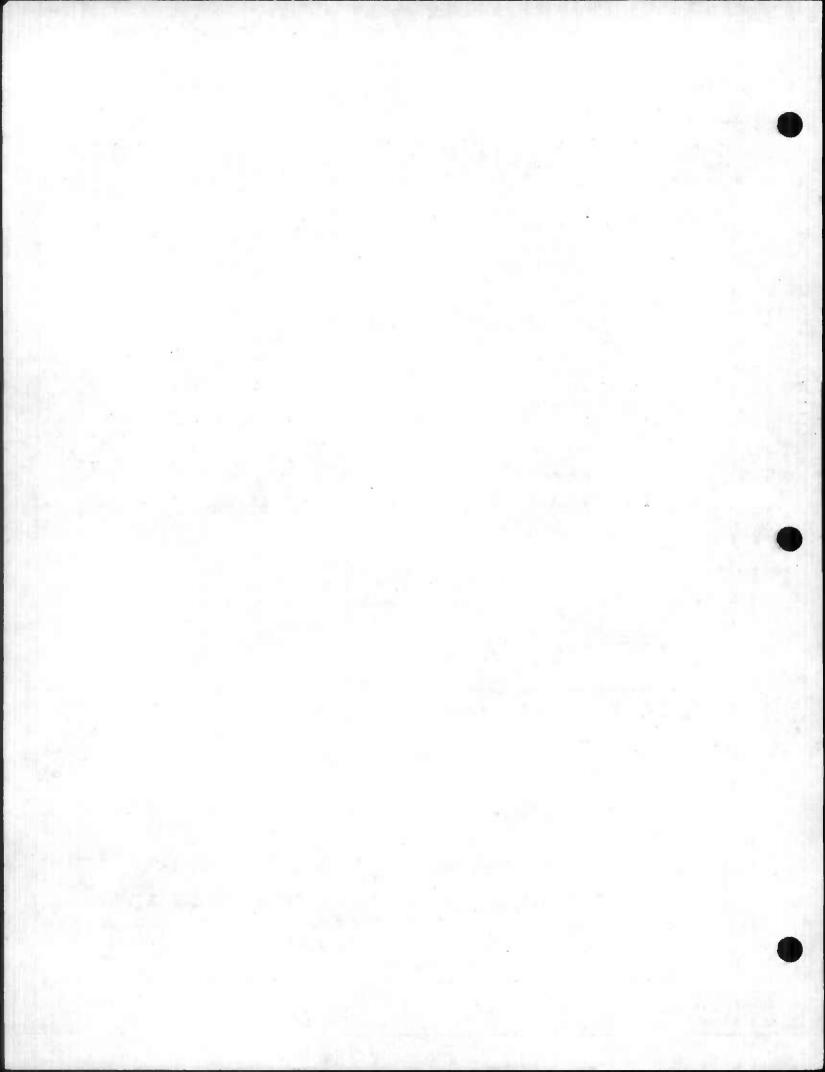
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

SERENA R. NOLAN, ND 8831 SAFYR HILL RD #100 BALTIMORE, NOD

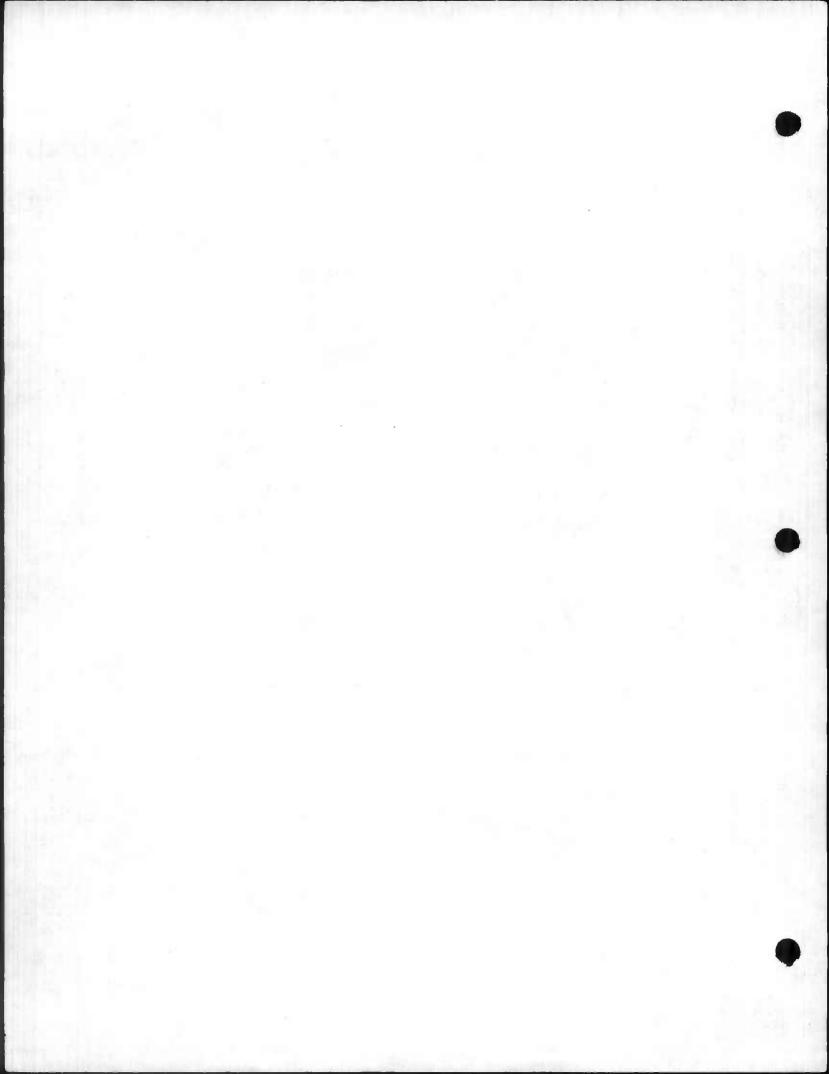
State Registrar

31. Date filed (Month, Day, Year) NOV 2 7 2000 32. Registrar'a Signature

ORIGINAL



					tificate of	Death		Reg. No.		1285
1. Decedent's Nama (F							2. Data of De Month	Day	Yaar	3. Time of Death
el Elitta McCa							Nov.		000	7:30 PM
4s Facility Name (If no			er)			4b. City, Town, or L		1		2
Genesis-Sp						Annapolis			Arunde	
5. Social Security Numb	32 1	ex	Age (In yrs. le 87	Yrs.	Months Days		8. Data of Bird (Month, Da JUNE 30	y, Year)		ce (Stata or Foreign v) vlvania
Usual Residence of De 10a. State 10	Ob. County		10c. City.	, Town or Loc	ation				10d	I. Inside City Limits
. 577	N/A			ginia :						1 N Yas 2 No
10e. Street and Number 3973 Old		Pood	16.		10f. Zip Code	F.2		10g. Citizen of \		17
	rorge	12. Was Decede	ent Euros in II S	1 12 14	234	J Z Hispanic Origin? (Sp	posity Van or No		JSA e - Amarican	Indian
3 Widowed 4 □	LEE PARTY	Armed Force 1  Yas 2 If Yes, Giva Year or Date	es? XNo	If	Yas, specify Cub	Specify:	Rican, atc.)	Blac	ck, Whita, etc.	
	. Decedent's Ed only highest gra			16a. Decede	ent's Usual Occup ind of work done	pation during most of world)	king	16b. Kind of B	usinass/Indu	stry
Elementary/Seconda	ary (0-12)	College (1-4	or 5+)			-,		O T	T	
	st, Middle, Last)			non	nemaker	18. Mothar's Nam	a (First, Middla,	Own I		
Thomas Mo							challeu			
19a. Informant's Name	/Relationship (	Type, Print)		19b. Mailing	Addrass (Street	and Number or Ru	ral Routa Numbe	er, City or Town,	Stata, Zip C	ode)
Richard N	Meehan			363 E	erbyshi	re Lane,	Riva, M	1. 2114	10	
20a. Method of Disposit			00	ace of Dispos	ition (Nama of atory or other pla	ce)	Data	20c. Location	City or Town	n, Stata
1 Donation 5			ara		iral Ceme		/22/00	Philade	elphia	. Pa.
Sequentially list conditing any, leading to immediate cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last  Part II. Other significants.	ng Iny	b	Dua to (or	as a consequal as a c	ence of):					
Part II. Other significan	nt conditions o	ontributing to deat	h but not resul	lting in tha un	derlying causa gi	ven in Part I.	23b. Did	tobacco une co	ntribute to ti	he cause of death?
							10	Yes 2000	3 Probe	bly 4 Unknown
							24a. Was	an autopsy rmed?	avail	a autopsy findings able prior to pletion of causa ath?
							10	Yas 2000	10	Yas 2□ No
25. Was case referred	to medical					26. Place of Dea	th (Check only o	ona)	1	
examiner?		Hospital:	atient 2 E	R/Outpatient	3□ DOA Oti	her: Mursing H	ome 5□Resi	dence 6 Oth	nar (Specify)	
2 ☐ Accident	☐ Pending investigation		njury Day Year)	28b. Time of Injury	28c. Inju Wo M 1□	ry at rk? ] Yas 2 ☐ No		how injury occur		
4 Homicide	determined	28e. Place of	Injury - At hor etc. (Specify)	na, farm, stre	et, factory, office	- 1	281. Location (: City or To	Street and Numb vn, Stata)	ber or Rural F	Routa Number,
			s of axamination			me, date and place opinion, death occu				
29b. Signature and title	of continer				29c. Licens			29d. Data signe		
N 4	1 10	mount	)		03	2136		11/20	60061	
100	/ / // > )				0	- /-				
30. Name and entress	at person who	completed cause of	of death (Item	23a) (Type, P	Janes Orah	· Orwa	Ch.	La mo	29/1	019



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Morris yshawn November 21,2000 1900 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospita Hopkins Bultimore Johns n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1□M 20 F Yrs. 214-45-2967 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No HARFORD JOPPA TOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21085 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 107 KENYON 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) ALBERT MORRIS RHONDA SMITH 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ROBERTA MARTIN HENRY/GRANDMOTHER 1839 FULTON ST., BROOKLYN, NY 11233 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removel from State 11 21 200 LONG ISLAND, NY PINELAWN CEM 4 Donation 5 ☐ Other (Specify) 21/Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217 the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death 23a. discharged disease, or complications that cock, or heert feilure. List only one cause on Immediate Ceuse (Final disease or condition resulting In deeth) 24 hours Due to (or as a consequenca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 No 3 Probably 4 Unknown iabetes Insipidis 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 20 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 27. Menner of Death 28b. Time of Injury 28d. Describe how Injury occurred 5 Pending investigation 1 Natural Accident

68760. Box P.O. Records, this certificate Division of Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rai", or items 23a or 28a-f ahow Examiner must be notified at

natural', or

permit. Peges 1 and 2 should be filt Department of Health end Mentel th Important: If Nem 27 is marked oth any Injury or other traumatic even Pace.

**Physician** 

/Medical

Examiner

filed within 72 hours after

3altimore, Maryland 21215-0020

Directo

Funeral

Completed

Physician/Medical Examiner þ Be Completed Certification: To

To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica completely filled in by the funeral director; to edical

29a. Certifier (Check only one) 29b. Signatu

3 Suicide

4 Homicide

6 ☐ Could not be

November 20, 2000 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify)

20:00 M

Automobile

1 ☐ Yes 2 No

Motor Vehicle Collision

28t. Location (Street and Number or Rural Route Number, City or Town, Stete) f. 24, Belair,

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D005 2994 29d. Date signed (Month, Day, Year) November 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMAL MURARKA MD, GON N. WOLF MD, 600 N. Wolfe St., Blalock 904, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

32. Registrar's Signature

**ORIGINAL** 

DHMH 16 Rev 6/95

Registrar

City State of the 
And the same of th

Marine Stranger Williams and the Stranger Strang

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#### Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Dey Month Yeer 1705 Mary E. Newberry 11 23 00 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Madical Joseph Conter Towson Baltimore Co. If Under 1 Yaar Months Days if Undar 24 Hrs. 8. Deta of Birth October 18,1921 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1□M 20 F Hours Months Baltimore, Maryland 79 217-12-7483 Usuai Residence of Decedent 10a. Stete 10c, City, Town or Location 10b. County 10d. Inside City Limits Maryland N/A 1X Yes 2 □ No Baltimore 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code 2116 Westfield Ave. 21214 United States of America 12. Was Dacedant Ever in U,S. Armed Forces? 1 XI Yes 2 □ No If Yes, Give Yaer or Detes: 14. Race - American Indien Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, atc.) 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Wave W.W.II Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Manager Chester Uniform 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Leo Charles Geraghty Mary Estelle Ray 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Ms. Michelle D. Breau(Grand Daughter) 3 F Roberts Path Sparks, Maryland 21152 20e. Mathod of Disposition 1 ☐ Buriai 2 ☐ Crametion 3 ☐ Ramoval from Stete 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 11/25/2000 Hilltop Service Corporation Towson, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) ral Service Licensee, Jeffrey L. Gair, Sr. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, art fallow. List only one cause on each line. 1050 York Rd. Towson, Md. 21204-2515 Approximete Interval Between Onset and Deeth Immediate Cause (Fine) 24 hoyes disaese or condition rasulting in death) Due to (or es e consequence of). Due to (or as a consequence of): Due to (or es e consequença of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown Vascular Disease

**Physician** /Medical Examiner

> tha signed by the

should I

certificata be executed ettanding physician and for use as the bunel-tran

Box 68760,

Division of Vital Records, P.O.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

2

Examiner

Physician/Medical

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Certification:

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**Funeral** 

Director

the Menyland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Menylan Department of Health and Mentle Hydine.
Important: If then 27 la merked other than "natural", or flams 23a or 28a-f ahow any injury or other traumatic event, the Mendle Executes count for nothing any

3altimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest Atheroscleratic

24a. Wes en eutopsy performed?

24b. Were eutopsy findings evailable prior to completion of causa of deeth?

2/2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

examiner?  Yes 2 No	
27. Menner of Deeth	i ☐ Pending

5 Pending investigation 6 Could not be determined 28e. Dete of Injury (Month, Dey Year) 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury et Work?

1 Yes 2 No

Ave

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Routa Numbar, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicida

4 T Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier wan 29c. License number H0055 992 29d. Date signed (Month, Dey, Year) 1231 00

Baltimore MD 21222

30. Name end eddress of person with completed cause of deeth (item 23e) (Type, Print)

Hospitei:

Debran L Gallo 31. Dete filed (Month, Dey, Year)

6730 Holabird 32. Registrer's Signeture

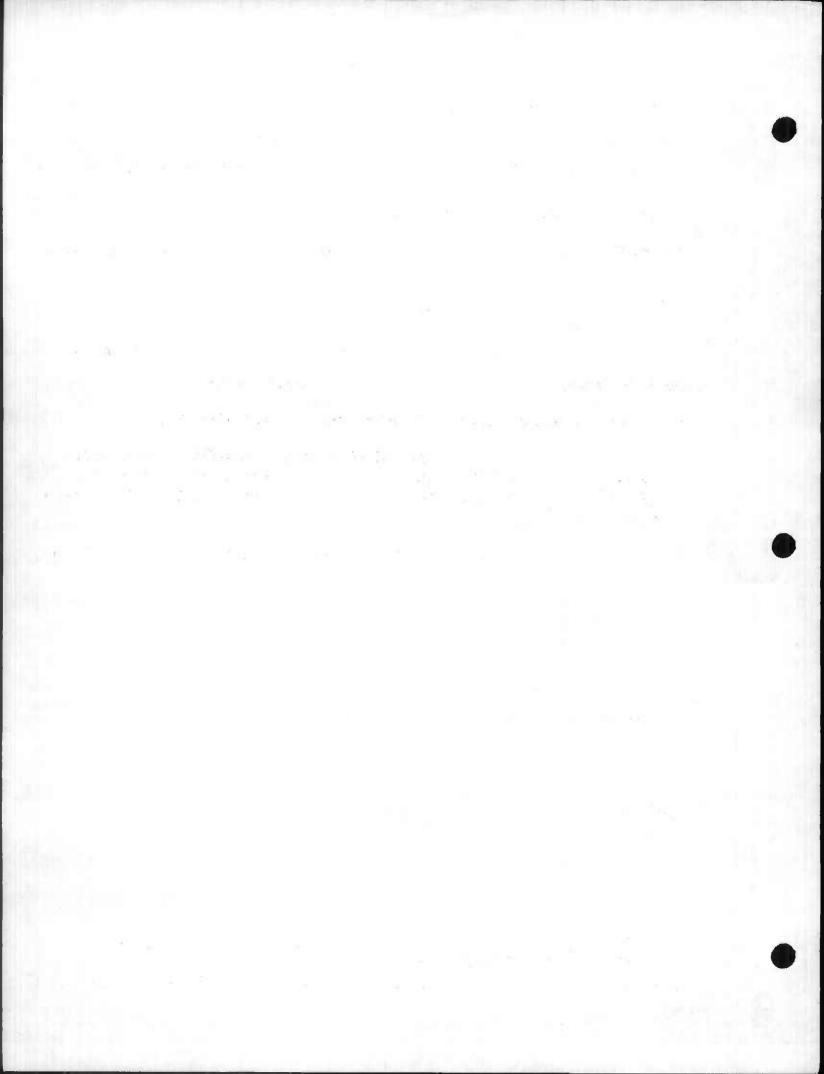
NOV 2 7 2000

O

Registrar

State

To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Year Month VESTOR 7.02A ELBERT 23 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year BALTIMORE Birthplaca (Stete or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Months Days Hours 1 M 20 F 232-24-1173 June 21, 1918 West Virginia Usual Residence of Dacedan 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 WARREN AVENUE U.S.A. 21230 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yas, Give 14. Raca -Bleck, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1942-45 WHITE 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 MACHINE OPERATOR GRIEF BROS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) JOHN D. NESTOR MINNIE FORTNEY 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) JOSEPH NESTOR/ SON 3821 FOSTER AVENUE, BALTIMORE, MARYLAND 21224 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Decremation 3 Ramoval from State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY INC. 11/27/00 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximete interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) PROBABLE PULMONARY ENBOLISM 25 minutes Due to (or es a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown BSTRUCTIVE PULMONARY DISEATE 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 152 Inpatient 2 ER/OutpetienI 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28h Time of 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - Al home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

physician and s the burial-transit deeth certificate be executed Box 68760. ettending ed by the a signed by t Records, The law page 2 s certificate has Division of Vital Physician: # funeral Attac Attending un after dea withth 24 hours at To the Funeral D completely lifed a

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

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permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manylan Destruction of Health and Mental Hygione. Important if Itam 27 is marked other than "natural", or items 23s or 28s-f show that injury or other treumstic avent, the Medical Exercises must be northed and the

**Physician** 

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Certification:

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29e. Certifier

(Check only one)

29b. Signeture end little of curtifiar

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

DANIEL BRODIE



, MD

600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINA

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner es stated.

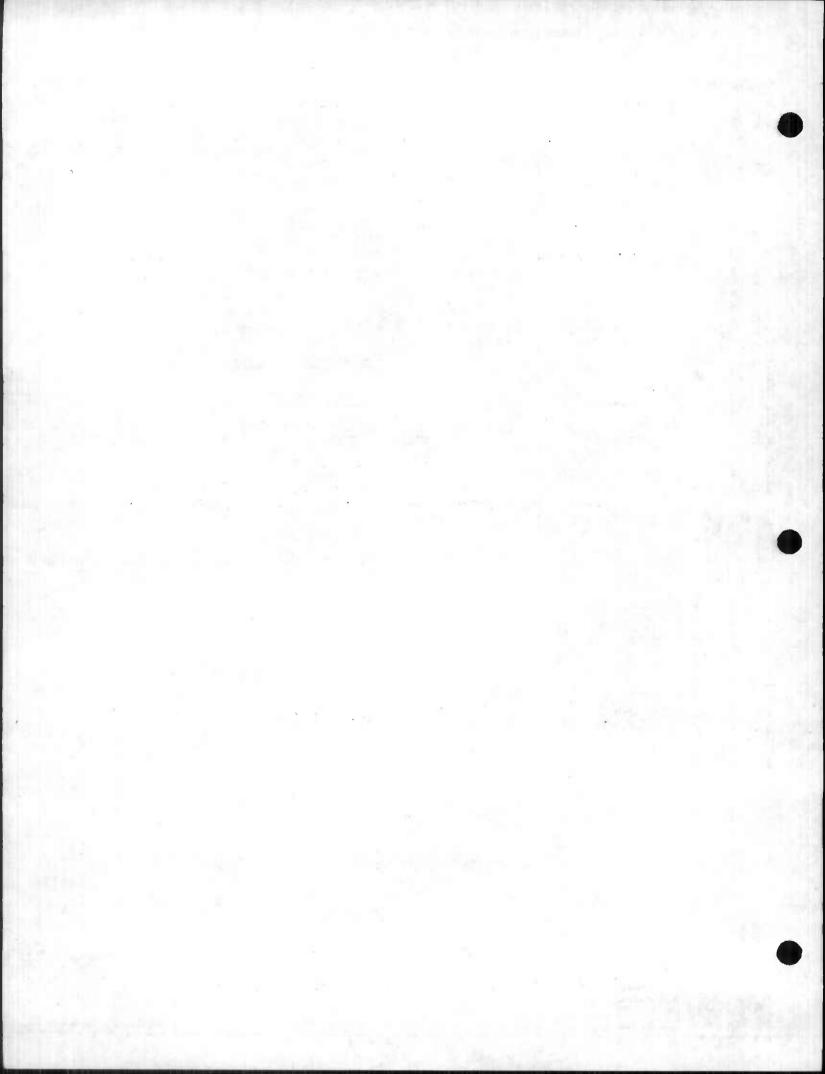
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29c. License number XE(

N. WOLFE ST, BAZTIMORE, MD 21287

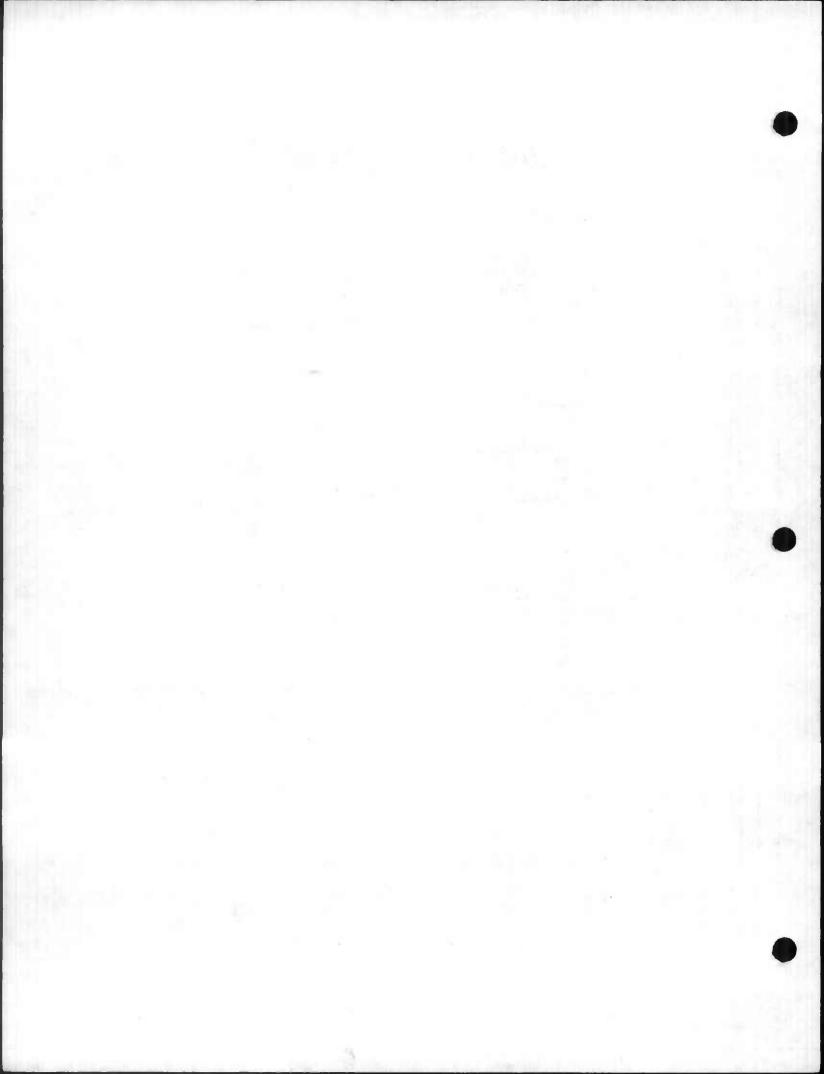
29d. Date signed (Month, Dey, Year)

NOVEMBER 23, 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:30/+M Nov.18,2000 Desiderio M. Orsini /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death **Examiner** Jarrettsville
| If Under 24 Hrs. | 8. Data of Birt 4045 Gilford Court Harford If Under 1 Year 8. Data of Birth (Month, Day, Year) 12/1/1924 9. Birthplace (State or Foreign Country)
Phila., PA 7. Age (In yrs. last birthday) 6. Sax X1X) M 2□ F **Funeral** Yrs. 75 Director 217-12-9175 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No result be notified Director Harford Jarrettsville Md 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21084 USA 4045 Gilford Court Funerai 12. Wes Decedant Evar in U,S. Armed Forcas? XX Yes 2 □ No If Yes, Giva Yeer or DateWW II Hems 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 72 hours after 1 ☐ Never Merried 2 Married 8 21215-0020 1 Yas 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 8 years Clerk Bethlehem Steel Corp. i. Pages 1 and 2 should be filed vitnern of Health and Mental Hygie tant: If frem 27 is marked other tigury or other traumatic event, to Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Assunta D'Onofrio Vincent Orsini 19a. Informent's Neme/Reletionship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Routs Number, City or Town, State, Zip Code) 9002 Fieldchat Rd Baltimore, MD 21236 Susan McLaughlin altimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Removel from Stete Department of Important: If any Injury or 4 Donetion 5 □ Other (Specify) Highview Memorial Gardens 11/21/2000 Fallston, MD 21. Signeture of Funeral Service Licensee 22. Nama end Address of Fecility E.F.Lassahn Funeral Home Lassals 23e. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** /Medical UREMIA Immediate Cause (Final disaesa or conditio resulting in deeth) Examiner Due to (or es a consequence of): & MONTHS END-STAGE RENAL FAILURE The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as e consequence of): DIABETES MELLITUS Box 68760. Physician/Medicai Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 HYPERTENSION 1 Yas 2 No 3 Probably 4 Unknown ۵ Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? PERIPHERAL VASCULAR DISEASE 1 ☐ Yes 2 10 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical examiner? edicai Certification: To Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 Yes 20 No this 28a. Dete of Injury (Month, Day Year) funeral 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Division Attending 1 Diffetural 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 26e. Plece of Injury · At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suiclda 28f. Location (Street and Number or Rural Route Number, City or Town, State) lilled in by 4 Homicide ò Hospital 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier To the Hosp within 24 ho To the Fune completely if (Check only one) 29b. Signature end title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) Andrew Nowakonski MD D08096 NOVEMBER 20, 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

ANPREW NOWAKOWSKI MI MD 125 N. MAIN ST BELAIR MP21014 31. Date filed (Month, Dey, Year) 32. Registrar's Signatura State NOV 2 7 2000 Registrar **DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene 00 37290

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er 4a	Facility Name (If not institut			nber)			4t	. City, Tow	m, or Loca	ation of Deel	h 4c.	County of	Deeth	
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30.	Name and address of person	on who cor	npleted paus	e of death (Iter	n 23e) (Type,	Print)						1	100	
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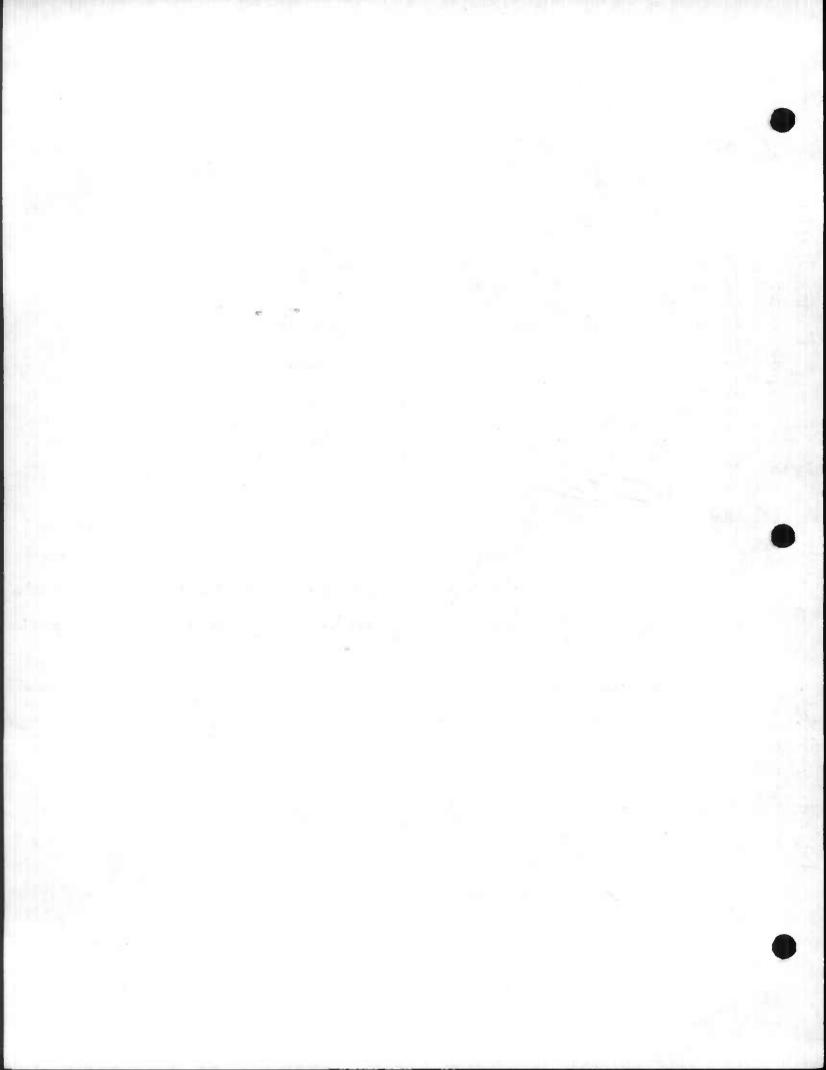
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Physician	Martha	Dorothy F						Month Novemb	Day	Year 2000	9:45 P
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Examiner						100					
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0 7 0	10e. Street and N	lumber				10f. Zip Code			10g. Citizen o	of What Coun	try?
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Examiner must by Funeral	3 Widowed	rried 2 Married 4 Divorced	12. Wes Decede Armed Force 1 Tes 2 If Yes, Give Yeer or Dete	es?		Vas Decedent of It Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	5pe	lace - Americ Bleck, White, city: Whit	etc.
'natural' adical Es		15. Decedent's Ed	ducation		16a. Deced	ent's Usual Occup	pation		16b. Kind of	Business/Inc	
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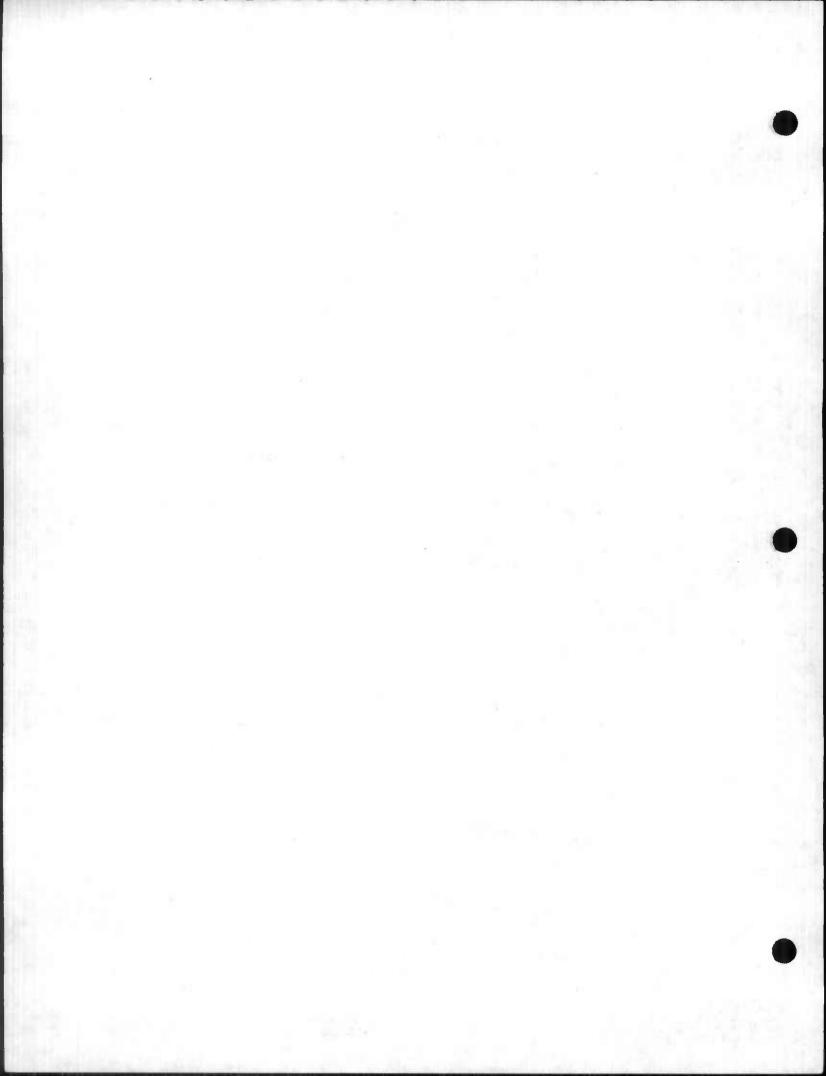
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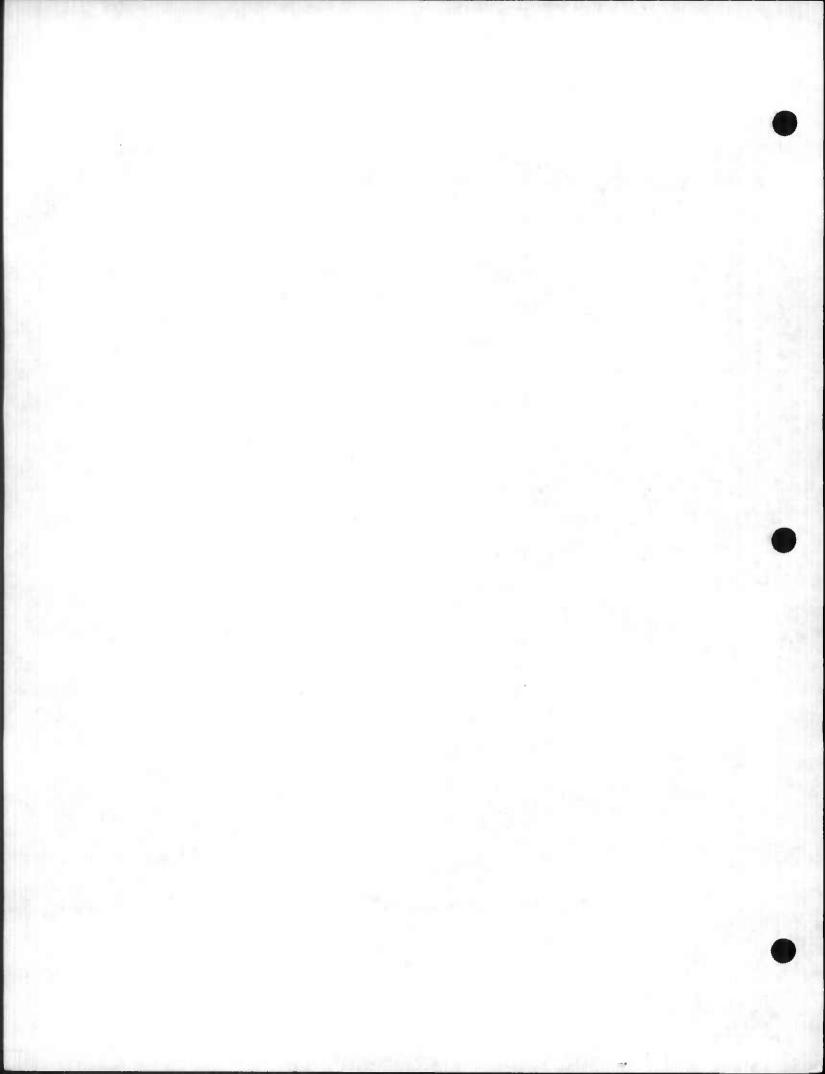


State of Maryland / Department of Health and Mental Hygiene 00 37293

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1. Comparison of the cause of t	Shound M		(Type, Print)	19b. P	failing Addre	ss (Street	and Number	r or Rural Rout	e Number, Ci	ty or Town,	State, Zip	Code)	
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Physician // Modical Examiner  23a. Part, Enter the desaes, or complications that cause the death. Do not enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween // Part II. Other enter the mode of dying, such as cerdiac or raspiratory arreal, Approximate interval Battween Only one)  Due to (or as a consequence of):  CONGESTIVE HEART FAILURE  Due to (or as a consequence of):  2a. Due to (or as a consequence of):  CONGESTIVE HEART FAILURE  2b. Due to (or as a consequence of):  2a. Due to (or as a consequence of):  2b. Use to (or as a consequence of):  2a. Due to (or as a consequence of):  2b. Use to (or as a consequence of):  2c. Turner (arread the mode of the cause of death of the	rtam njun			New Ca				11/2/	//2000	Balti	more	, Mary	Lan
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JOGINDER P. MEHTA M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204	1	Su Junia	1. 11.16	the m.	0 1	0041	1410		Mr	remhe	124		ren.
JOGINDER P. MEHTA M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204	3	30. Name and ddress of person wi	no completed cause of d	leath (ftem 23a) (T	/pe, Print)				1	- 1			
21 Date filed (Month Day Veer) 20 Desistants Cignature						DRIU	E TO	WSON.	MARYL	AND	2120	14	
	State							. 7					

**ORIGINAL** 

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 19, Margaret Mary Prehn Nov. 2000 6:15 AM 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 1723 Maple Avenue Hanover Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Hours 10 M 25 F 67 Yrs 214-30-3891 SEP. 16, 1933 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 25 No Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1723 Maple Avenue 21076 USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Howard County 12 Health Assistant Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Philip Peter Heil Martha May Smallwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Herman Prehn - husband 1723 Maple Avenue, Hanover, Md. 21076 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 11/22/00 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park Elkridge, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 11.3 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Brenst Cancer to Lungs Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause 24a. Was an autopsy performed? of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. Stata

**Funeral** 

**Director** 

23a or 28a-f show

8

72 hours after

Pages 1 and 2 should be nent of Health and Mental

Department of Health a Important: If item 27 is any injury or other trace

altimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

the burial-transit and US0 85 signed by the a page 2 certificata shis

The lew requires that the death certificate be axecuted

Box 68760.

P.O.

Division of Vital Records.

or Attending Physician:

Hospital

Examiner Physician/Medical þ Completed Be Medical Certification: To

after death. Director: Af 24 hours a

To the Hosp within 24 ho To the Fune completely fi

State Registrar

5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and titla of cartifier 29c. License number

28c. Injury at Work?

29d. Data signed (Month, Day, Year) November 20 Zas

28f. Location (Street end Number or Rural Route Number, City or Town, State)

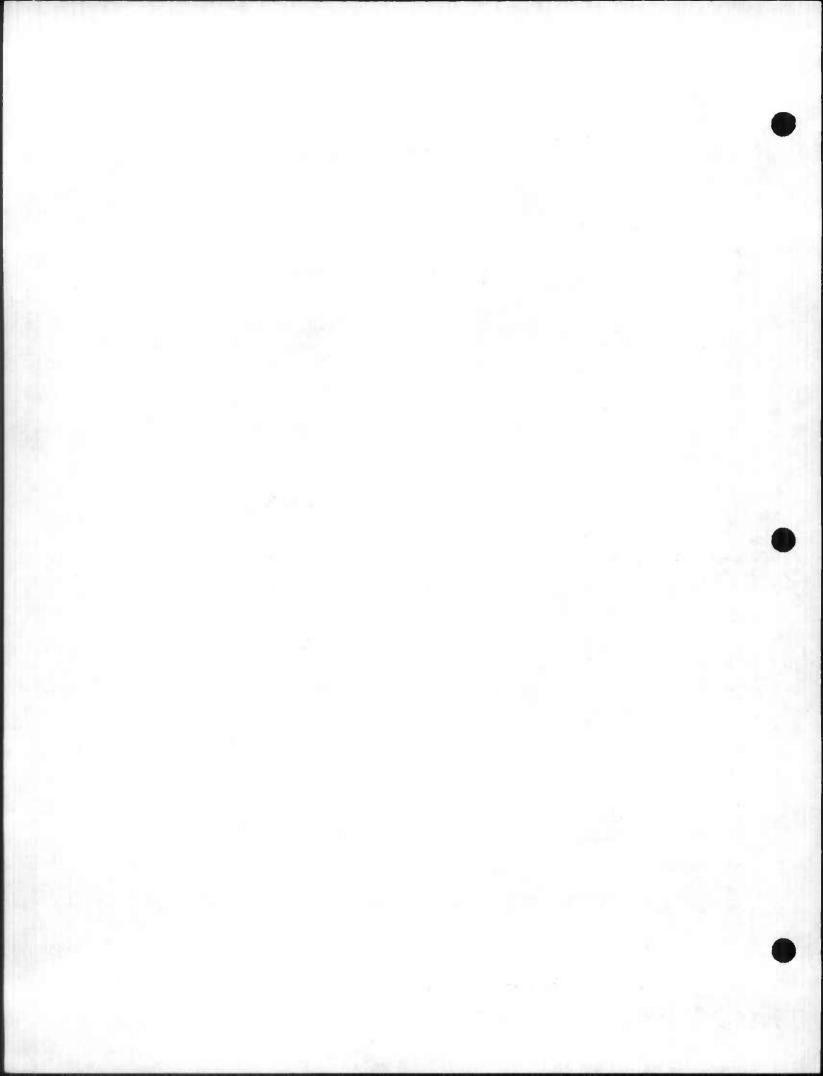
28d. Describe how injury occurred

30. Name and address of parson who go of death (Item 23a) (Type, Print)

Li 44/2 PATUSEUT Pky Columbias MD Koutrolates mo 11065 NICHOLUS lat-

28b. Time of

31. Date filed (Month, Dey, Year) NOV 2 7 2000 32. Registrar's Signature



		1. Decedent's Nama (First, Middle, Last)									2. Data of D	Reg. No.		3. Tima of Death
Physicia /Medica		Grace	The second secon	Pate	211a						Month Novemb	er 23, 20	Year	9:00pm
Examine		4a Facility Nama Friend	(If not institution is Nursing			nber)				4b. City, Town, or Sandy S	r Location of Dea oring, MD		ty of Death	
Funeral Director		5. Social Security 099-07-899		6. Sex	M 2√F	7. Aga <i>(tn yi</i> 88	rs. last birth Yı	Mont	der 1 Yaa hs Days		(Month, E	irth Pay, Year) Moer 26,	9. Birth 1912	placa (Stata or Foraig intry) NY
		Usual Residence	T											
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28a-f notifis	Directo	10e. Street and N	umber				70	10f.	Zip Coda			10g. Citizen of	What Cou	intry?
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the Medical			15. Decedent's Education (Specify only highast grada completed) antary/Secondary (0-12) Collega (1-4or 5+)				ife. DO NO	work don	i during most of w ed)	orking	16b. Kind of f	Business/Ir		
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Health and I am 27 is me other traums		19a. Informant's Paul F		,	Son					nt and Number or F d, Briancli			n, Stata, Zi 510	ip Coda)
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Depart Import any in	168	1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify)  21. Signatura of Funaral Service Licensee Victor P. Doda, Jr.  22. Nama and Address of Facility  Charles L. Stevens Funeral Home, Inc.												
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30. Name and address of person who complated cause of death (Item 23a) (Type, Print) James A. Rossi, MD 3305 North Leisure World Blvd., Silver Springs Maryland 20906

Rison me

31. Data filed (Month, Day, Year)
NOV 2 7 2000 State Registrar

29b. Signatura and titla of certifier



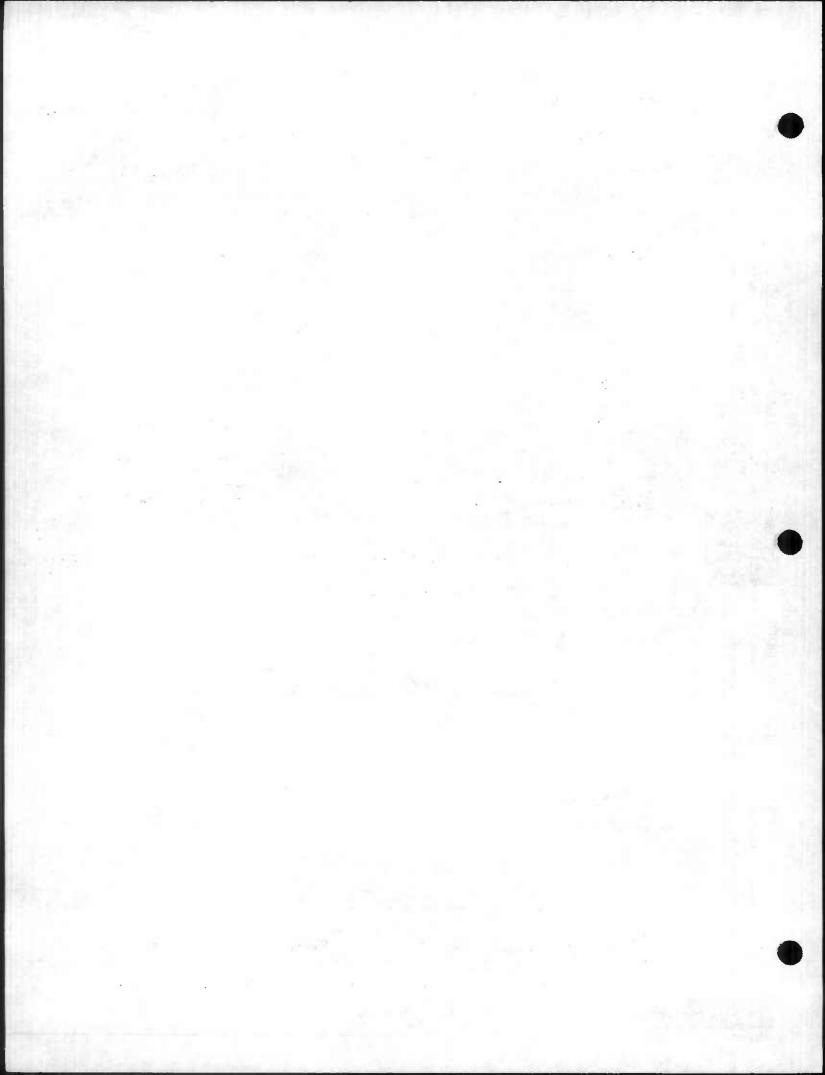
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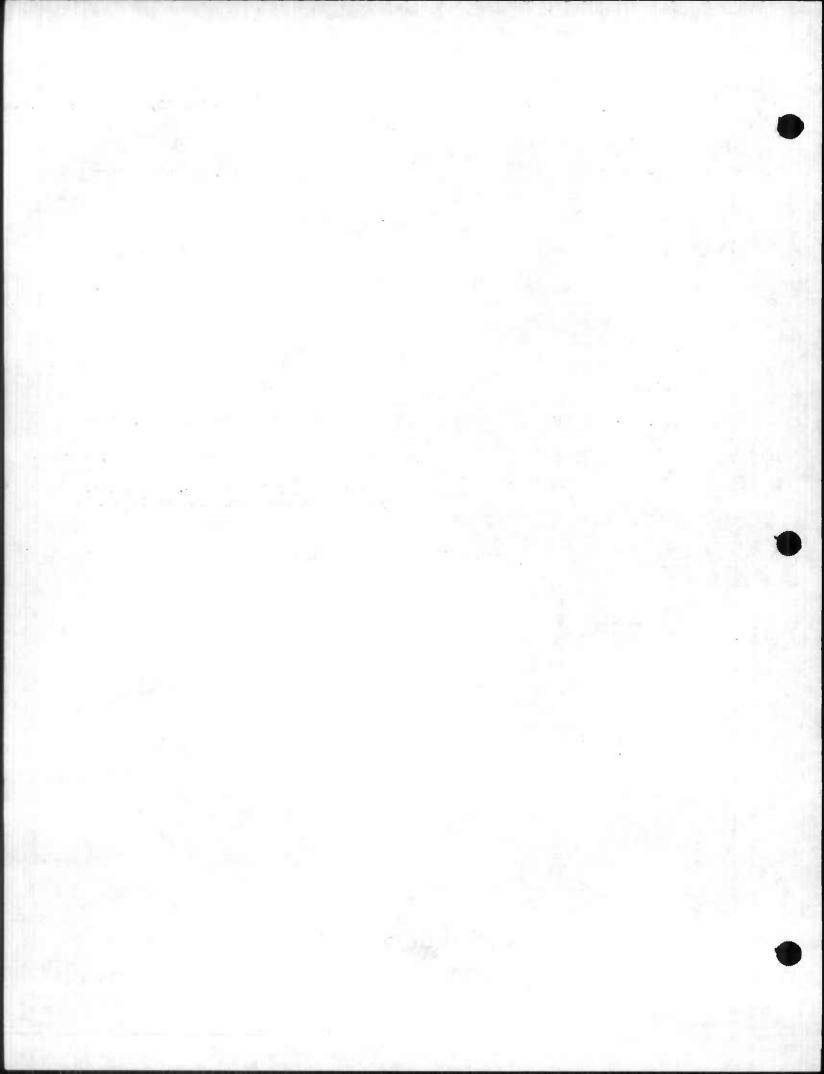
November 23,



State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death		Reg	. No.			
	1. Decedent's Neme (First, Middle, I	ast)					ata of Death			3. Time of D	eath
Physician (Madisal	Emma B. Po	lonesi					Month vember	23, 2	Year 000	5:50	p.m.
/Medical Examiner	4e Fecility Neme (If not institution, g	ive street end number)			4b. City, To	own, or Location	n of Deeth	4c. County	of Death		4.114
	4526 Todd Point	Lane			Balti	more		Balti	more		
Funeral	Social Security Number 6.		e (In yrs. last birthday	Months Dev		24 Hrs. 8. Do	ete of Birth Month, Day, Y	(oar)	9. Birthpl	ace (State or I	Foreign
Director	213-70-4077	1□ M 35XF	90 Yrs.	Months Dey	nours	Aug	g. 25	1910		land	
9	Usuel Residence of Decedent										
how	10a. Stete 10b. County		10c. City, Town or L	ocation					10	Od. Inside City	
cto cto	Maryland Baltim	ore	Baltimor	е						1 Yes 2	ZX_I No
within 72 hours after death with the Maryland ane. Than "natural", or fems 23a or 28a-f ahow the Medical Examinar must be notified a ompleted by Funeral Director	10e. Street and Number 4526 Todd Point	Tano		10f. Zip Code 21219				g. Citizen of V		•	
r tems 23 plost must Funeral	4520 TOUG FOITE										
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0 5	1 Never Merried 2 Merried 3 X Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Detes:	No	1□Yes 2ŽN	Specify:			Specify	Whit	e	
deal Err	15. Decedent's (Specify only highest of	Education rade completed)	(Giv	edent's Usuel Occi	e during mos	st of working	16	6b. Kind of Bu	usiness/Ind	lustry	1-17
	Elementary/Secondery (0-12) 7 years	Cottega (1-4or 5	i+)	DO NOT use retir emaker	red)			Own H	ome		
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2 2	Mrs. Shirley Bur										
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= 9	1 ☑ Burial 2 ☐ Cremetion 3	Removel from State	cemetery, cre	metory or other p		1					
jury	4 Donetion 5 Other (Spec	•		Cemeter		11/2	5/00	Baltim	ore,	Maryla	.na
important: If frem 27 any injury or other tr	21. Signeture of Funaral Service Lic	ensee		2. Name and Add			e of D	undalk	Tno		
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and be d							24e. Wes an	autopsy	24b. We	ere eutopsy fin	idings
page 2 should							perform	ed?	cor	silable prior to inpletion of cer	use
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	2 Accident invastigat	ha			☐ Yas 2☐	41					
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To the Funeral Director: completely filled in by the Medical Certifical		Physician: To the best of miner: On the basis of	examinetion and/or i								
completely filled Medical Co	29b. Signeture end little of certifier	and manner ste		29c Lice	nse number		29	d. Date signe	d (Month	Day, Year)	
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1//	16/10/20			'	4 3 1	03		1,1	-410		
1	30 Neme end address of person wh	o completed cause of d	eath (Itam 23a) (Type	Print)	FA	st a	110	210	21	230	
1	H-KOSE V	MUIVER	INID	701 6	FU	01 0	u	14/12	or,	30	
State	NOV 2 7 2000	32. Registr	er's Signeture	A. A.							
Registrar	2000	Mercan	15 15400	2003							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death November 23, 2000 **Physician** Provenzano Jeanette R. 7:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rossville Manorcare Nursing Center Rossville Baltimore Hours Min. Month, Day, Year)

Warch 17, 1914 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Days Months 10 M 20 F 86 217-05-6995 Maryland Director Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland 1X Yes 2 No N/A Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21206 4607 Hazelwood Avenue 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Statue Black White etc 1 Never Married 2 Married specify: White 1 ☐ Yes 2 ☑ No Specify: 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) Clothing Fitter 8th Grade 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) Francis Cimino Josephine Cimino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2015 Kelbourne Road Baltimore, MD 21237 Bam 27 Emanuel J. Provenzano/Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 33/00 11/27/00 Baltimore, Maryland 4 Donation 5 (Nother (Specify) Entaribment | Most Holy Redeemer Cemetery 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name end Address of Facility Leonard J. Ruck, Inc. d. Hilton hustina 5305 Harford Road Baltimore, Maryland 21214 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner DIONALA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) TOVENZAM Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heci dent Cerebro - VASCULAT Records, 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed anette 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case refarred to medical examiner? 88 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 9No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month. Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural Division 1 TYes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide after Olre Descrifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Registrar NOV 2 7 2000

31. Date filed (Month, Day, Year)

Muneses

Jude

32. Registrar's Signature

7845

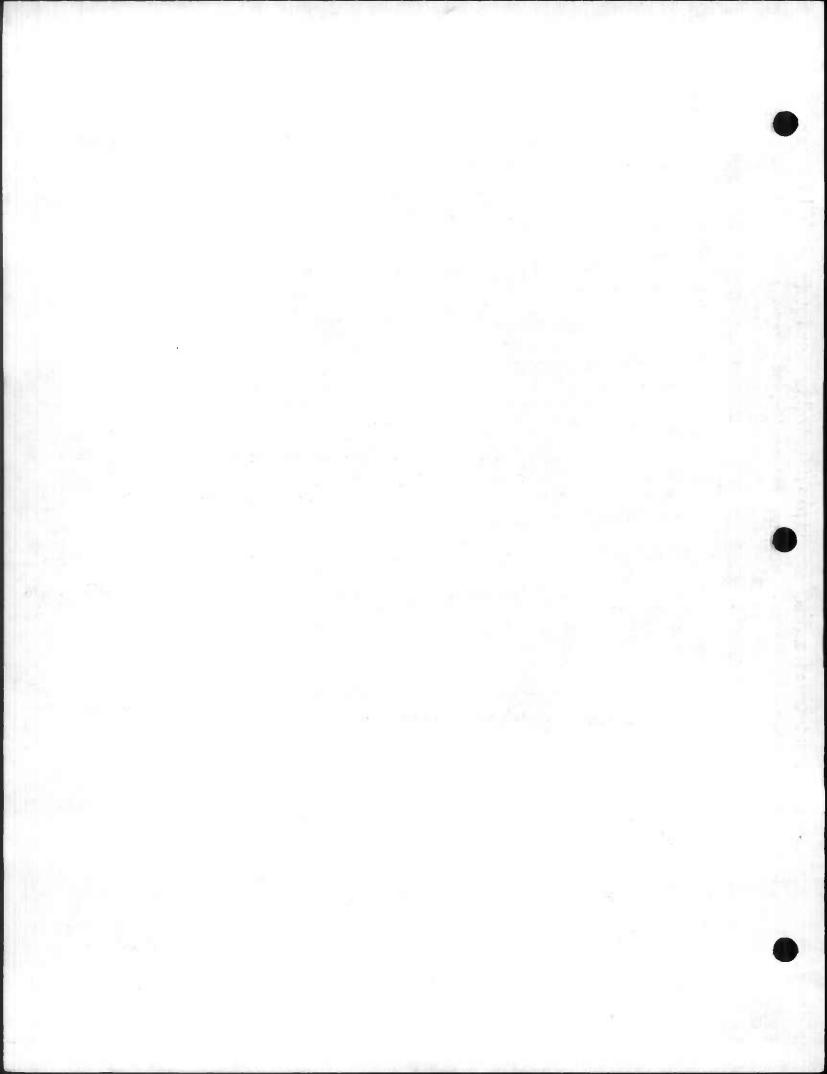
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

B. Special

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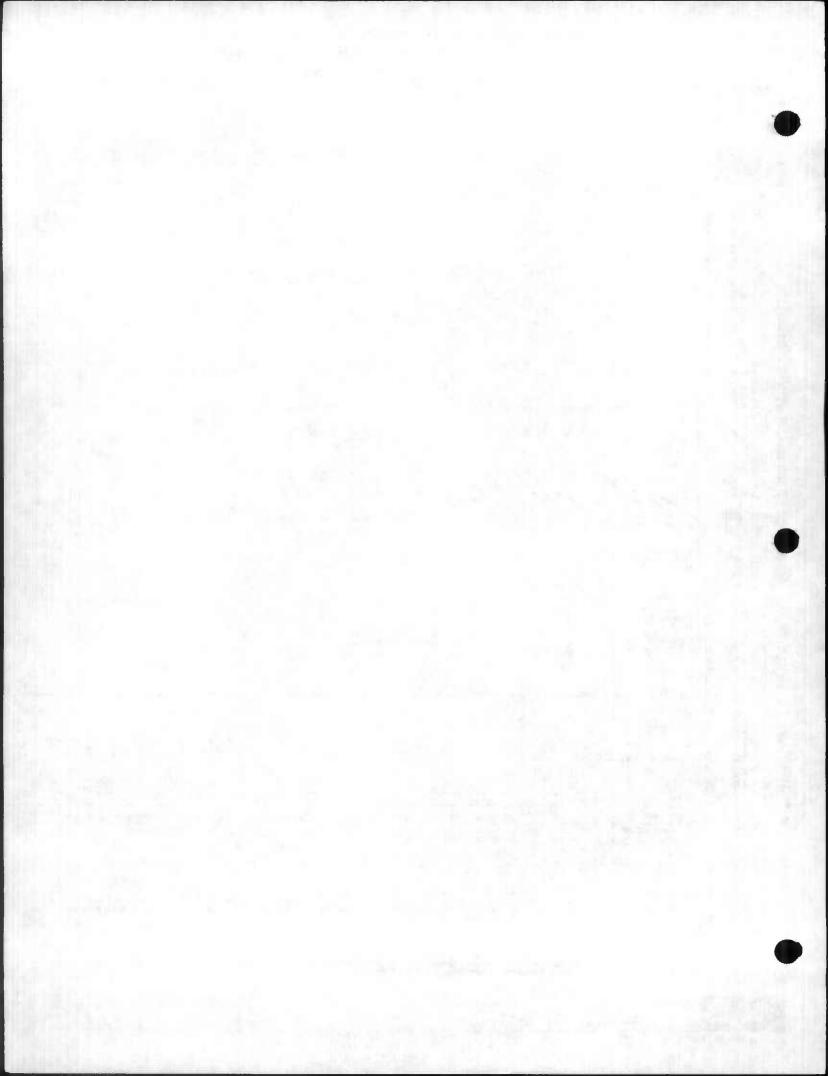
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	er me G791 1/23/01 y			Cer	tificate of	Death		g. No.				
Physician	Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Dey	Year	3. Time of Death		
Physician /Medical	DaMia I	aycha I	Pauling	11.75			NOVEMBE			05:08 AM		
aminer	4a Facility Name (If not institution,	give street end numb	er)			4b. City, Town, or L	ocation of Death	4c. County	of Death			
	UNIVERSITY HOSP	ITAL				BALTIMORI	<b>T</b>	N	/A			
	5. Social Security Number (		Age (In yrs. las		If Under 1 Year Months Days		8. Date of Birth (Month, Dey,	Vaeri	9. Birthpl	lace (State or Foreign try)		
115	213-59-2599	1□M 2፟XX		O Yrs.	2 23			2000		YLAND		
	Usual Residence of Decedent											
	10e. State 10b. County		10c. City, T	own or Loc	ation				10	0d. Inside City Limits		
by Funeral Olrector	MARYLAND N/A			BAL'	FIMORE			U 19 14		1X Yes 2 No		
Sire	10e. Street and Number				10f. Zip Code		10	g. Citizen of	What Coun	try?		
8	2432 LAKEVIEW A	VENUE			21	217		U.S	. A .			
5	11. Marital Status	12. Wes Decede Armed Force	nt Ever in U,S.	13. W	as Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	14. Red	ck, White,			
2	1 XX ever Married 2 ☐ Marrie				☐ Yes 2KIXNo		Thours, otc.,					
	3 ☐ Widowed 4 ☐ Divorced	Yeer or Dete	s:		- 162 STER	Specify.		Specify	BLA	CK		
5	15. Decedent's (Specify only highest		1	6e. Deced	ent's Usual Occu	pation during most of work	ing 1	6b. Kind of B	usiness/Ind	lustry		
npidu	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. D	O NOT use retire	ed)						
Be Completed	0 yrs			N/A				N/				
26	17. Father's Name (First, Middle, La	ast)				18. Mother's Nam	e (First, Middle, M	laiden Suman	ne)			
10	LIONEL JOHN PA	ULING				RUTH LE	E BARDNE	Y				
	19e. Informent's Neme/Relationshi	p (Type, Print)		19b. Meiling	Address (Stree	at and Number or Rur			State, Zip	Code)		
	Lionel Pauling	/Father	10,00	2432	Lakevie	w Avenue,	Baltimo	re. Md	21	217		
	20e. Method of Disposition		cem	a of Dispos	ition (Name of etory or other ple			Oc. Location				
	VOXBurial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		te				1 20 00	D 3 T M T 14	000			
1	21. Signature of Faheral Service Li	-	ME		Name end Addr		1-28-00	BALTIM	ORE,	MARYLAND		
	V/1/2 /10	16 19	1- 11	W:	ILLIAM C	BROWN CO	MMUNITY :	FUNERA:	L HOM	E PA		
	San Back Ector the disease or h	contrations that cause	and the death			RTH AVENU		et		Approximate		
(	23a Past Enter the disease, or of hock, or heart failure. List of	nly one cause on each	line.	DO HOL BING	in the mode of dy	ing, such as cardiac	or respiretory arre	31,		Interval Between Onset end Deeth		
an al	Immediate Cause (Finel		11111									
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	that initiated events resulting in death) Last		Due to (or as	a consequ	ence of):							
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an		U.		E								
Completed by Physician/Medic	Pert il. Other eignificant condition	contributing to death	but not resultir	ng in the un	derlying cause g	iven in Pert I.	23b. Did tot	oacco uae co	ntribute to	the cause of death?		
E I							1 □ Ye	2 PA0	3 Prob	bably 4 Unknown		
2												
8							24a. Was an	autopsy	24b. We	ere eutopsy findings aileble prior to		
2							poriorii		COL	mpletion of cause death?		
5							1 Deye	s 2 No		ores 2□ No		
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0 00	examiner?	Hospitel:	Mana althur	10.	οΠ 20. O	ther	th (Check only one			.4		
. To	1 XYes 2 No 27. Menner of Death	1 L Inpa		Outpatient  b. Time of	3LI DOM	4 U Nuising no	ome 5 Resider			V)		
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5	2 Accident investige 3 Suicide 6 Could no	t be	Inluma At 1	. faces			20f Leasting (Co.	and and the	hor or Duc	I Pouto Atumbas		
9	4 Homicide determin	ad 200. Placa of	Injury - At home etc. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Location (Str. City or Town,	, State)	oer or Mu/8	n noute reumber,		
THE STATE OF												
Certifle	29e. Certifier  (Check only 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menne											
icai Certific	(Check only 2 Medical Ex	caminer: On the besis	OI GYARTINI MILITORI				, 000	h				
Medical Certification:	(Check only 2 Medical Ex	aminer: On the besis and menner	steted.									
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completely filled in by the Medical Certificat	(Check only 2 Medical Ex	and menner	steted.	Be) (Type, F	OCT		N	OVEMBE	ER 22,	, 2000		

State Registrar NOV 2 7 2000

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Rosamond G. Revnolds 430 pm November 21 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore franklin Square Hospital Center Rosedale tf Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□ M 2 F Months Deys Hours 220 18 9530 75 Director Nov. 12, 1925 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2K No Maryland Baltimore must be notified Directo Middle River 23s or 28s-1 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1320 Chesapeake Avenue 21220 IISA Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Merried ò 1 ☐ Yes 2 ☒ No Specify: Specify: White à 3 ₩ Widowed 4 Divorced Yeer or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Bookkeeper Metal Fastener Mfg. 12 17. Father's Neme /First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Mental Thomas Nesbit Laura Lamphier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) * Sharon Crum (Daughter) 7310 Gunpowder Rd. Baltimore, Md. 21220 of Health : If Items 27 h Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Pages 1 Buriel 2 □ Cremetion 3 □ Removel from State Oak Lawn Cemetery 11/25/2000 Baltimore, Co. Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility
Bruzdzinski Funeral Home P.A. MO1091 1407 Old Eastern Avenue Essex, Md. 11. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, ock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical · Ovarian Cancer 3 years Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Lest Due to (or es e consequence of): 68760 the Due to (or es e consequence of): USB BS Box ( P.O. detached Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown signed Gastrointestina Breding, Anemia of Vital Records, Be Completed by page 2 should be 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Lolon Cancer, Gastro Duo Denal ulcer this certificate has 21500 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Piace of Deeth (Check only one) Hospitel: Popatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🗆 🕜 o Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Menner of Deeth 1) Deaturel 2 Accident 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation after death.

Director: Aft
d in by the fur 1 Yes 2 No 3 Suicide 6 Could not be 28e. Plece of fnjury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D | Medical Examiner: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

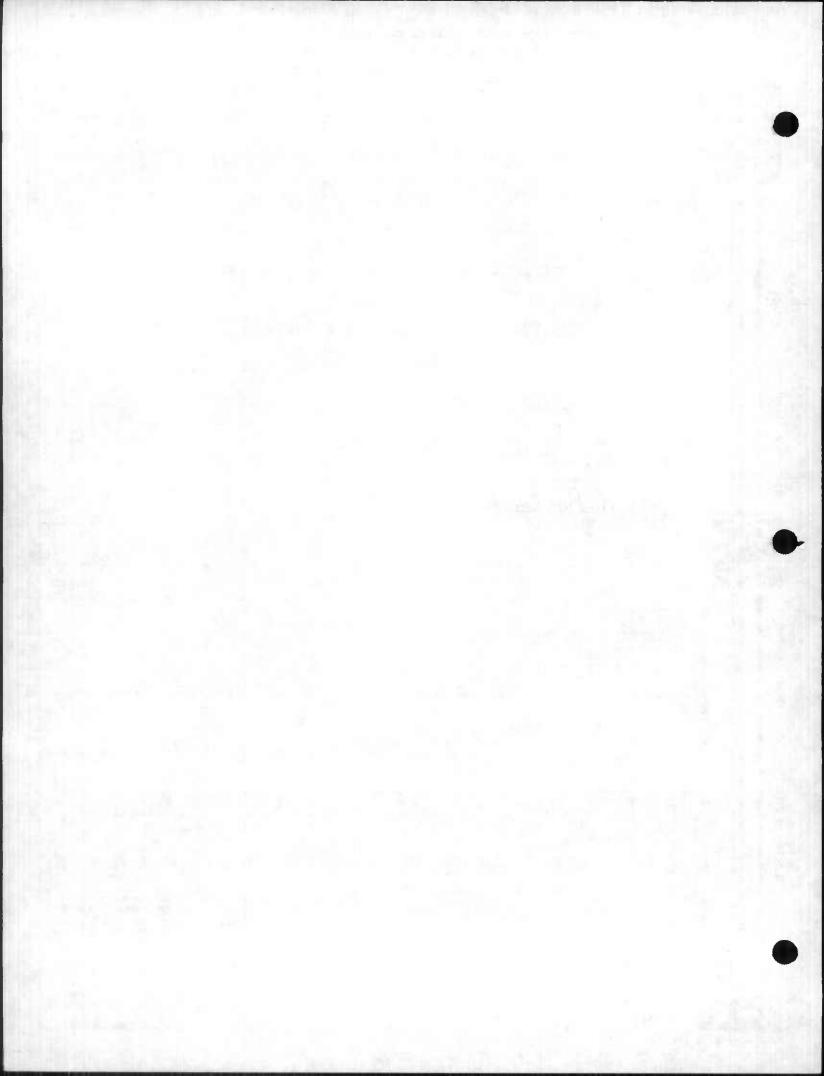
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner stated. 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 21 auna, Mp completed cause of deeth (Item 23e) (Type, Print) 9000 Franklin Square Drive Baltimore Maryland DR Marco Zami ta

State Registrar

31. Dete filed (Month, Dey, Ye. NOV

32. Registrer's Signeture

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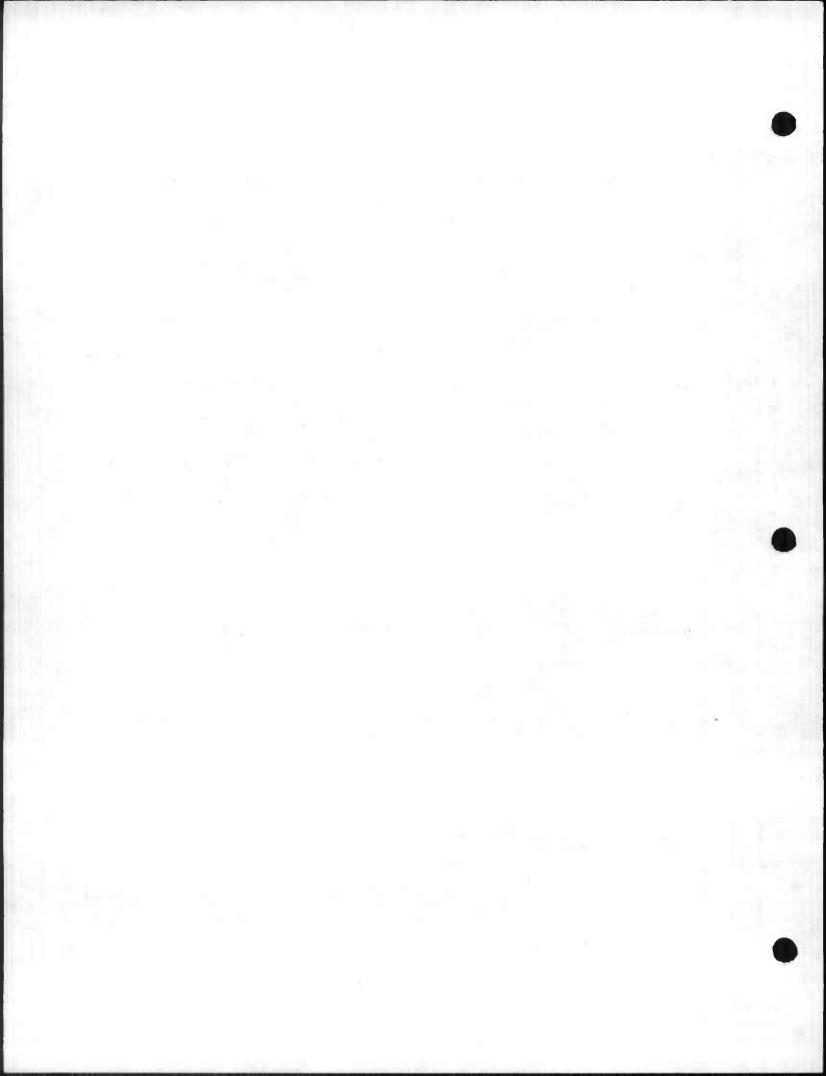


State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death Month // Humber Physician 20 1040 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Multi Medical Towson Baltimore If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 5. Sociel Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M Months Director 215-44-1192 December 31,1918 North Carolina Usual Residence of Deceden 10e State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No r. must be notified Maryland Directo Baltimore Towson 10e. Streat and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or liams 23s or 7700 York Road 21204 LISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: Specify. þ 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teacher Private School permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other? 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be George Hiram Humber Florence Marion Ackiss 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) Stephen C Redd SON 425 Oak Lane Towson, Maryland 21286 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Burial 2 Cremetion 3 Removel from Stete Sherwood Episcopal Ch Cem 11/25/00 Cockeysville, Maryland 22. Name end Address of Fecility Mitchell-Wiedefeld Funeral Home Inc. 21. Signature of Funeral Service Licenses 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) Examiner 1 week welmo N Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that Initiated events resulting in death) Last attending physician and for use as the burial-trar Box 68760 Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vitai Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Heart P 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2 1 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completaly filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28h Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Metural 5 Pending Investigation 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29a. Certifier (Check only 29b. Signature and little of central 29c. License number 29d. Date signed (Month, Day, Year) D17118 No 21 2000 completed cause of death (Item 23a) (Type, Print) MA 21212 1(T Year) 32. Registrer's Signeture State 2 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yaar 1145 am 2000 November Elsie Mae Richard 4c. County of Deeth 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Union Memorial Hospital Baltimore If Undar 1 Yaar 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Min. Months Days Hours 1 M 2 KF 79 MD 212-12-9029 01 - 10 - 21Usual Residance of Dacedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits X Yas 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2021 Robb Street 21218 USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2☐No Specify: 3 ₩idowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) High Sch. Grad Housewife in home 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alfred Nicholson Marcella Cornish 19a. Informant's Name/Retationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Nicholson 2021 Robb Street Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD. Nat'l Mem. Pk.Cem. 11-25-00 Laurel Co, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilura. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disaasa or condition resulting to death) Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Hiknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1□ Yes 2 No 1 Yas 20 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Apatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Delatural 1 Yes 2 No 2 ☐ Accident

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**Physician** 

/Medical

Examiner

**Funeral** 

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To the Hospital owithin 24 hours aff To the Funeral Di completely filled in

State Registra

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6 Could not be determined

29c. License number

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) November 21, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore IND 21218

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

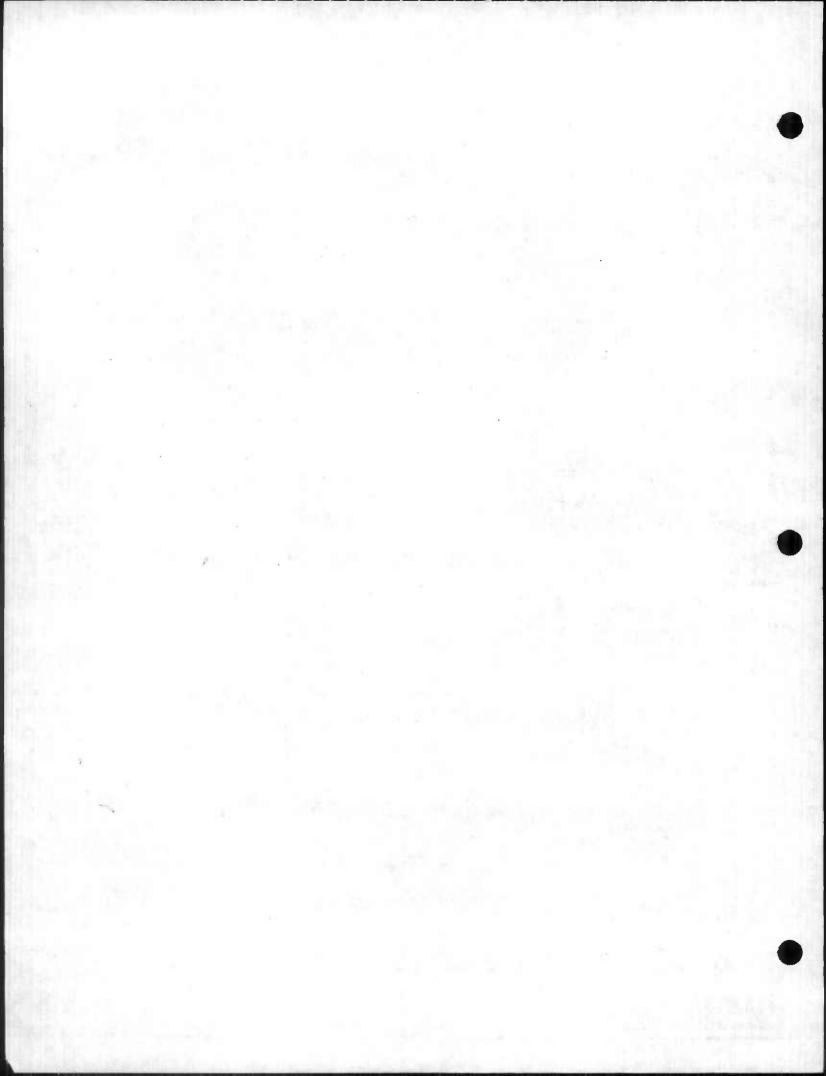
201 E. University PKW4

31. Date filed (Month, Day, Year) NOV 2 7 2000

29b. Signature and title of certifier

32. Registrar's Signatura

park ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 20 1344 4c. County of Death /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death Examiner Be a l 0 Viedi ente 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 12-8086 1 M 2 F Director Usuel Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location show 10d. Inside City Limits ma 23a or 28a-f short mark be notified at Maryland 1)X Yes 2 □ No Funeral Director 9e W00 10e. Street and Number 10f. Zip Code 10g. Citizen of What Countr 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Herna 11. Meritel Stetus 14. Race - American Indien. the Medical Examiner Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Merried ò 21215-0020 1□ Yes 2⊠No Specify Be Completed by 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be file ment of Health and Mentel Hi lant: If item 27 is marked oth 0 eorge Johnson bec a 0 19e. Informent's Neme/Reletionship (Type, Print), (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 21040 ae Wood other Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date 1 Buriel 2 □ Cremetion 3 □ Removel from State 8 29/2000 Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 00 21. Signaffore of Funeral Service License 22. Name and Address of Facility Joseph ease, or complications that caused the death. Do not enter the mode of dying, such as cardiare. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Severe Covanan disease or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 | Yes 2 | No ai cure Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Si this certificate has 1 Yes 2 No 1 Yes 2 No or Attanding Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Metural death. 1 Yes 2 No Hospital or Attandit
 24 hours after death.
 Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier completely (Check only one) within 2 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number D. 16444. ending November 20th 2000 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)  $VIJAY \cdot S \cdot NAIRMD \cdot 2112 BEL$ 

Registrar **DHMH 16 Rev 6/95** 

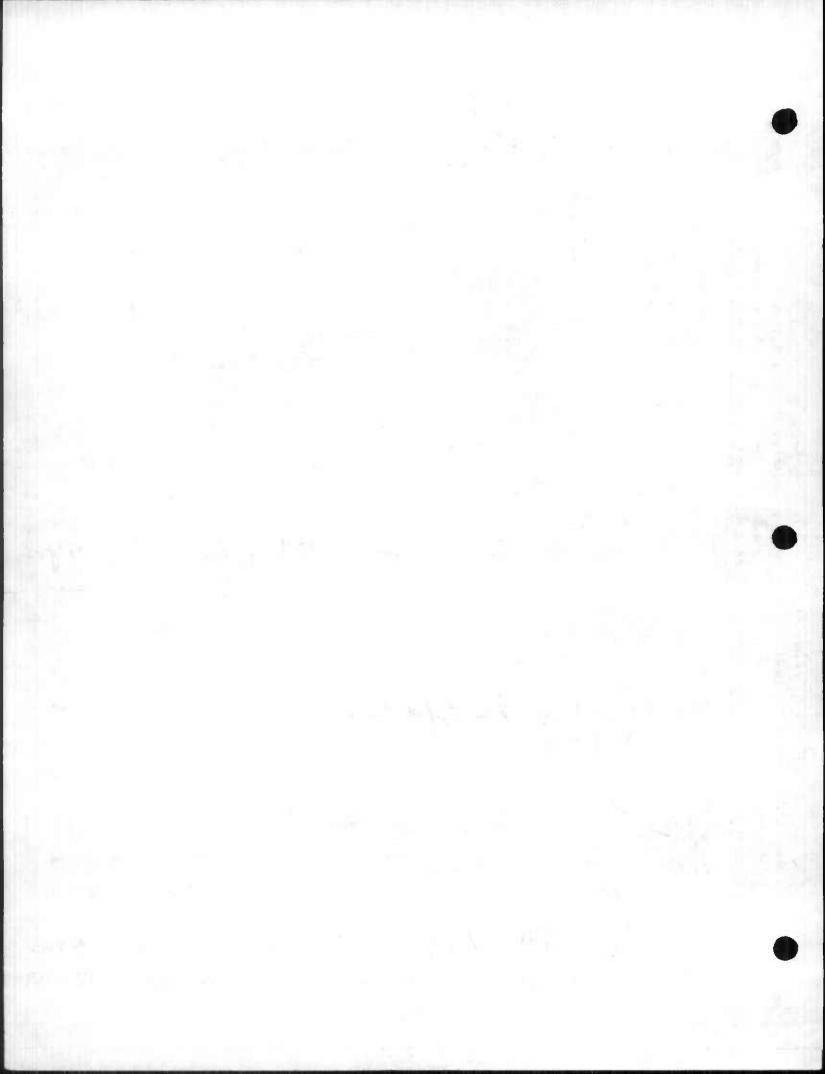
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2000

32. Registrar's Signature

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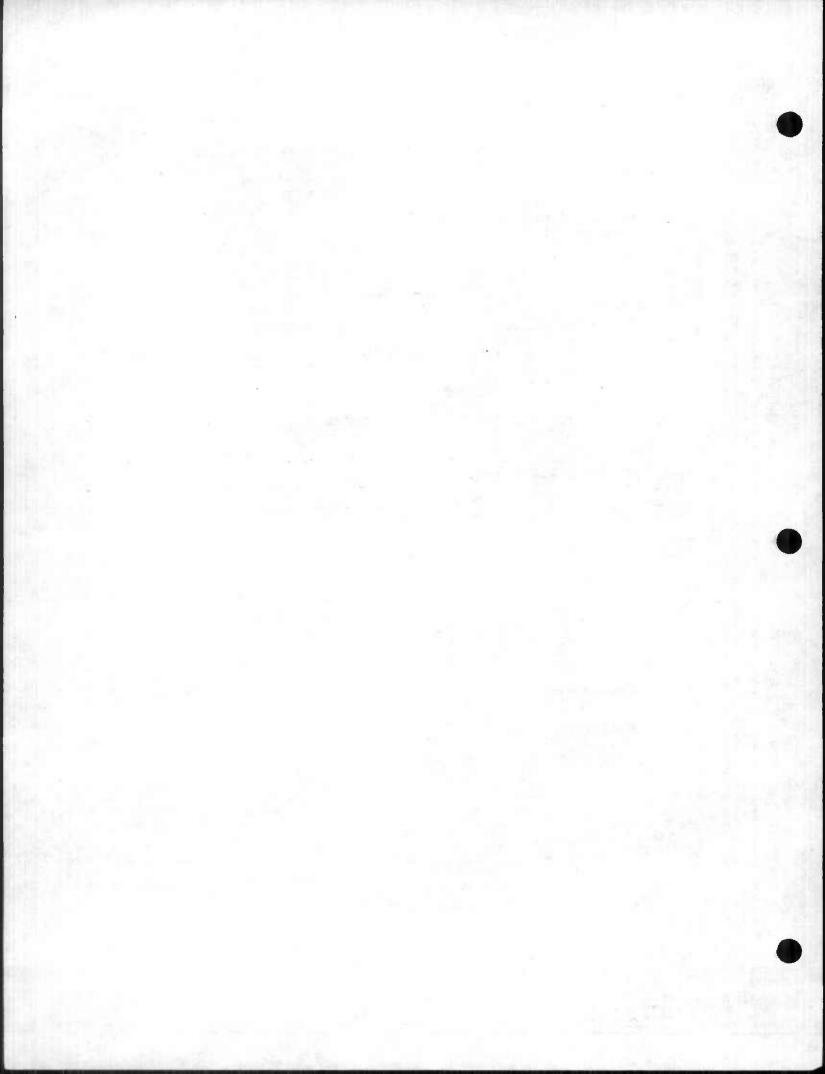
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Exam		4a Facility Name	a (If not institution, giv	a street and numb	er)				4b. City, Town, or	Location of Deat	4c. County	of Death		
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lary 2 sho 2 sho and N		19e. Informant's	Name/Reletionship	Type, Print)		19b. Me	elling Addre	s (Street	and Number or R	lural Routa Numb	er, City or Town,	State, Zip	Code)	
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Division of Vital Reports to the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier (Check only one)		nysician: To the besi	s of exemine									ise(s)
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	)	30. Nama and a	deess of person who		of death (Itan		pe, Print)	Can	onAvene					
	itate	31. Data filed (N	fonth, Day, Year)		istrar's Signa	atura	,				,			
Regis		NOV 2	7 2000	Benery	19.	. A	Docks	1						

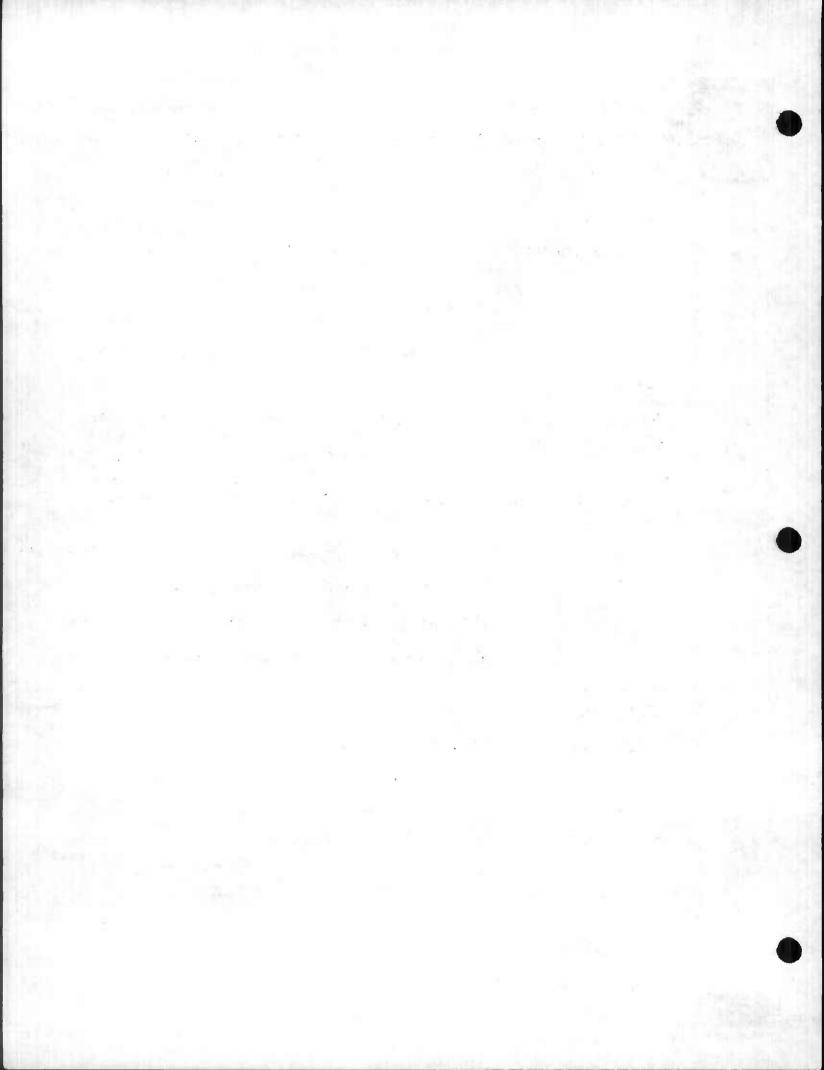
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				Certificate	of Death		Reg. No.		
Div. sistan	1. Decedent's Name (First, Middle, Las	0				2. Date of I	Death Day	Year	3. Time of Death
Physician /Medical	Leonard A. Rossba	ch				Novem	Der 23 2	2000	4.43pm
Examiner	4a Facility Name (If not institution, give Franklin Square			, (	4b. City, Town, or Roseda		ath 4c. County	of Death	e
Funeral Director	5. Social Security Number 6. Se		e (In yrs. last birth	day) If Under 1		. (Month.)		9. Birthpi	lace (Stata or Foreign try) Maryland
	Usual Rasidence of Decedent					NOVERB	JCI 0, 14	734 1	alylana
Je Je	10a. State 10b. County		10c. City, Town	or Location				10	0d. Inside City Limit
vith the Mary o or 28=1 eh be notified.	Maryland Baltimo	re	Dundal						1 ☐ Yes 2 ☑ N
death with the Maryland rms 23s or 28s-1 show frings be redified at neral Director	10e. Street and Number 8041 Stratman Roa	ıd		10f. Zip C 21222	000		10g. Citizen of V		•
5 2 3 5	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 XYas 2 If If Yes, Give		If Yes, specify	nt of Hispanic Origin? ( Cuban, Mexican, Pua	Specify Yes or I rto Rican, etc.)		e - America ck, Whita, e	
030 036 bv	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Dates:		1□ Yes 2√	No Specify:		Specify	Whi	te
Maryland 21215-0036 Alexandra Should be filed within 72 hours effer with and Mental Hygiene.  27 to marked other than "natural", or he rearmatic event, the Mental Exercises Traumatic event, the Mental Exercises.	15. Decedent's Ed (Specify only highest grad	de completed)	()	Decedent's Usual ( Give kind of work ife. DO NOT use	Occupation done during most of we retired)	orking	16b. Kind of Be	usiness/Ind	lustry
/ CV TITLE U	Elementery/Secondary (0-12)	College (1-4or s		staller			Communi	catio	ons
Maryland 2 2 should be filled in and Mental Hygin reumatic event, if	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Midd	le, Maiden Sumen		0,110
Vlan Wental Mental To Be	Leonard W. Rossba	ch			Mary L	. Marti	1		
should menter umeric	19a. Informant's Name/Relationship (7		19b. f	Meiling Address /:	Street and Number or F			Steta. Zin	Code)
lore, Maryland ; ges 1 and 2 should be file; in of Health and Mental Hy in them 27 is marked othe or other traumatic event,	Maureen Rossbach				an Road D				
re, M s 1 and 3 f Health hem 27 other tr	20a. Mathod of Disposition	(	20b. Place of D	Disposition (Neme	of	Date	20c. Location -		
Baltimore, Mar Baltimore, Mar Department of Health and mortant: If them 27 to may	1 Burlal 2 Cremation 3 4 Donation 5 Other (Specify		cemetery,	p Servic	e Corp.	11/27/0			
Baltim Permit. Pa Department Important:	21. Signature of Juneral Service Licens	-11/	7	Dud - Du	Addrass of Facility Ck Funeral	Home of	E Dundalk	, Inc	C.
	23a. Part1. Enter the officese, of companions, or heart failure. List only of	olications that caused	d the death. Do no	t enter the mode	of dying, such as cardia	ac or raspiratory	arrast,	ind 2.	Approximate
Physician /Medical		a a (chy	thmia						Intervel Between Onset and Death
Examiner	resulting in death)	a	Due to (or as a co	insequence of):					
9		, Coror		rtocu	diseas	30		1	
owcuted an and inal-trensit  Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. CON (O)	Dua to (or as a co	nsequenca of):	O. Sea	76-			
O. Box 68760, he deeth certificate be executed the attending physician and shed for use as the burial-transit ysician/Medical Examir	rasulting in death) Lest	C	Dua to (or as a cor	nsaquance of):					
P.O. Box that the deeth certified of by the attending deteched for use a province of Physician/M		d						i	
Se de de la	Part II. Other significant conditions co	entributing to death b	ut not resulting in t	he underfying cau	ise given in Part I.	23b. D	d tobacco use co	ntributs to	the causa of deati
P detection						11	Yes 2 No	3 Prot	bebly 4 Unkno
Shoul				See 1		24a. W	as an autopsy rformed?	ave	ere autopsy findings allable prior to mpletion of cause death?
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f Vital Revyelon: The lavyelon: The lav director, page 2						11	Yes 2 No	11	Yes 2 No
Vita	25. Was case referred to medical axaminer?	Hospitai:				eath (Check onl	y one)		
hysic aldires	182 163 20 140	1 L Inpatie					sidence 6 Oth		y)
Division of Vita hal or Attending Physician: is after death. In Director: After this certification by the funeral director. Certification: To Be (	27. Manner of Death  1 Neturei 5 Pending  2 Accident invastigation  3 Suicide 6 Could not be		ry Year) 28b. Tir y Year) Inju	me of 280 ury M	: Injury at Work? 1 Yes 2 No	28d. Descrit	e how injury occur	red	
Divi	3 Suicide 6 Could not be 4 Homicide determined	Zoe. Pieca of inj	ury - At home, fam c. <i>(Specify)</i>	n, street, factory,	office	28f. Location City or	(Street and Numb own, State)	oer or Rura	il Houte Number,
Division o  To the Hospital or Attending Ph within 24 hours after death.  Completely filled in by the funeral  Medical Certification:									
Within With	29b. Signature and title of certifie			29c. I	icense number		29d. Dete signe		Dey, Year)
	1////	MO		Do	0055000		11/23	100	
11/18	30. Nama and address of person who c	ampleted source of d	leath (Item 23a) (T	Point)	e Drive b	altina			7
U- V	DR TODD Larab			1 39001	e onve D	WI SITT ON	E 11102	1251	1
State Registrar	NOV 2 7 2000	Seren Seren	ar's Signature	parts					

DHMH 16 Rev 6/95



amend item 19b per fh G789 11/27/00 yf Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RUBIN 3.40 /1 MOVEMBER 20, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER RANDALISTOUN NON THUEST HSPIML BALTIMORE If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 10 M 20 F 218-16-1843 Yrs. Director JUN.4,1925 Usual Residence of Decedent 10d. fnside City Limits 10e. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Director BALTIMORE MD N/A 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be r 4160 CRESTHEIGHTS ROAD 21215 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No WWII
If Yes, Give
Yeer or Dates: NAVY 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 WHITE 1 Yes 2 XNo Specify: Specify þ 3 Widowed 4 Divorced NAVY Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN RETAIL SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be filt.
Department of Health and Mental Hy important: If Item 27 is marked oth eny Injury or other traumatic event other. Be RUBIN ANNA 0 SAMUEL FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 4160 CRESTHEIGHTS AVENUE -BALTIMORE, MD 21215 FRANCES RUBIN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/22/00 BETH EL MEMORIAL PARK RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Deel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final VENTRIGIAR FIBMULATION 45 minutes disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner 15 Litem 4 CANDIOMYOJATH Y EARC burial-trans Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue physician s the burial CORONAM YEARS Annon Physician/Medical Due to (or as a consequence of): DIABETES MELLERS YEMS SMMDING USB Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown CHRONIL RCUAR signed to PV 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed VASLULAR DISEASE pege 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Natural 2 Accident 5 Pending investigation or Attending after death. Director: After 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of de 400.20 2000 MO ss of person who completed cause of death (Item 23a) (Type, Print) FINE NO 5401 OLD LOURS CANDAUSTOWN MD 71133 LOBER 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 2 7 2000 Registrar **DHMH 16 Rev 6/95** 



#### Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Reiness November 22,2000 Evelyn 6:30 AM 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Randallstown Northwest 8. Date of Birth (Month, Day, Year SEP . 8, 1917 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Days Months Hours 1 M 2 X F 83 215-10-3315 **Usual Residence of Decedent** 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE RANDALLSTOWN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9006 HAMOR ROAD 21133 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Merried 2 Married 1 Yes 2 No Specify: WHITE Specify. 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PROPRIETOR TAVERN 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SOL KAPLAN MAMIE SNYDER 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON PARIZER / DAUGHTER 9006 HAMOR ROAD - RANDALLSTOWN, MD 21133 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete BETH EL MEMORIAL PARK 11/24/00 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Nama and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximata Intervel Between Onsat and Death Immediate Cause (Finel disease or condition resulting in death) Coronary Arten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Cerebrousscular Accident Dua to (or as a consequence of) Aortic years Stenosis Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 40 Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy 1 ☐ Yes 2 No 200 No 1 Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Minpatient 2☐ ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

The lew requires that the death certificate be executed pue P.O. Box 68760, the detached for use as ate has been signed by page 2 should be detac certificate funeral director. this After

Examiner Physician/Medical à Completed Be Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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filed within 72 hours after

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Pages 1 and 2 should be filed in ment of Health and Mentel Hygis ant: If Nem 27 is marked other

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Department important: If eny injury or

Physician /Medical

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permit.

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altimore. Maryland

Funeral Director

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Completed

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**DHMH 16 Rev 6/95** 

State Registrar

Christopher J.
31. Date filed (Month, Day, Year) NOV 2 7 2000

3 Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifier

30. Name and address of pe

Davis

6 Could not be

ompleted cause of death (Item 23a) (Type, Print) 2401 West 32. Registrar's Signeture

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Beliebere Avenue

00055609

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29c. License number

November 22, 2000

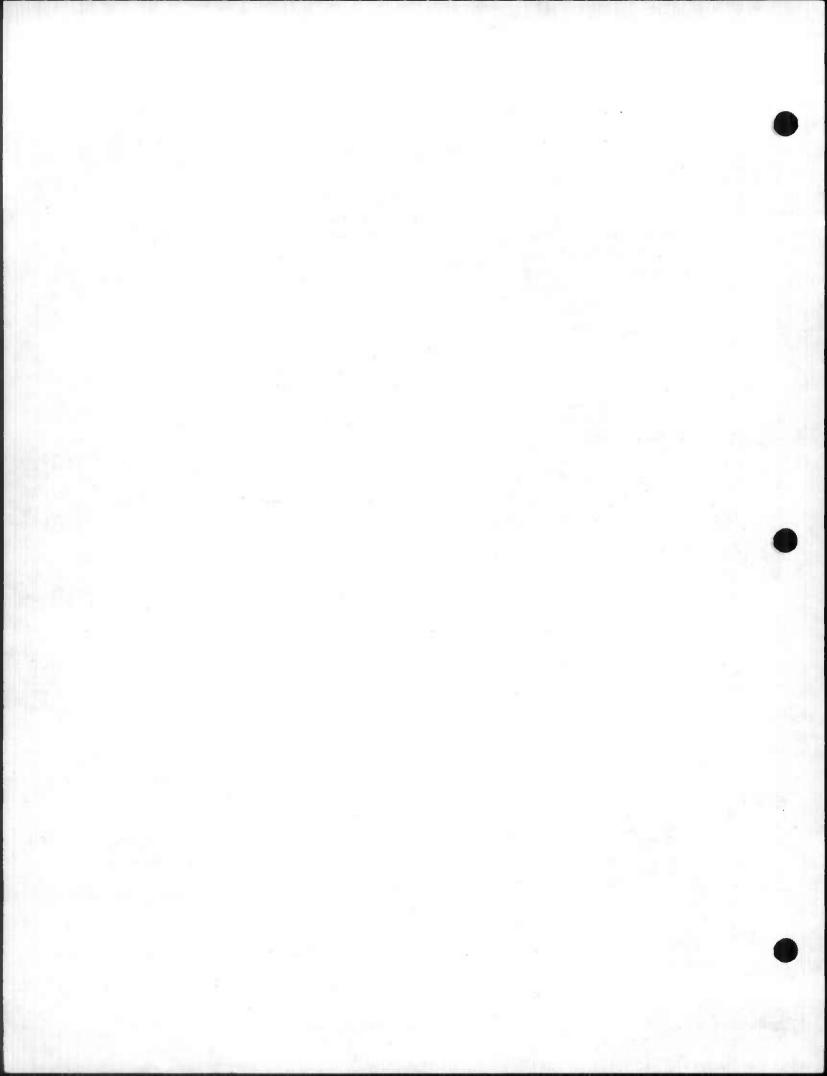
29d. Date signed (Month, Day, Year)

Battimore, Maryland 21215

28f. Location (Street and Number or Rural Route Number, City or Town, State)

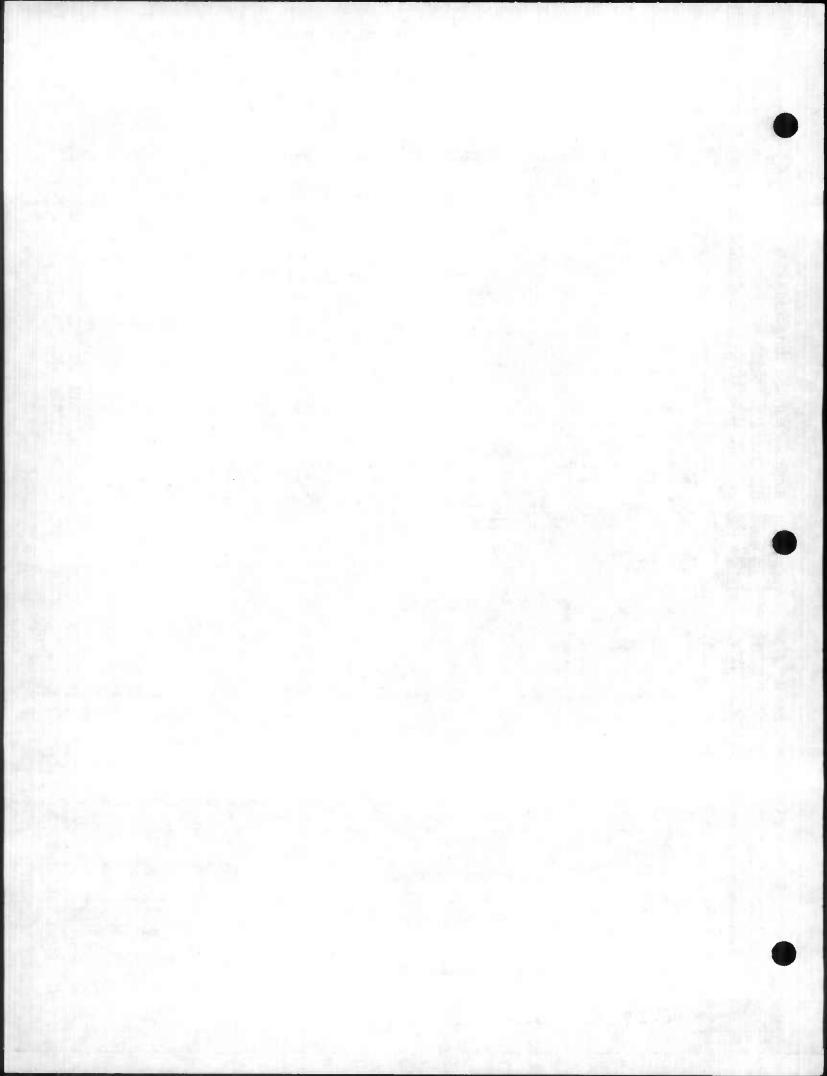
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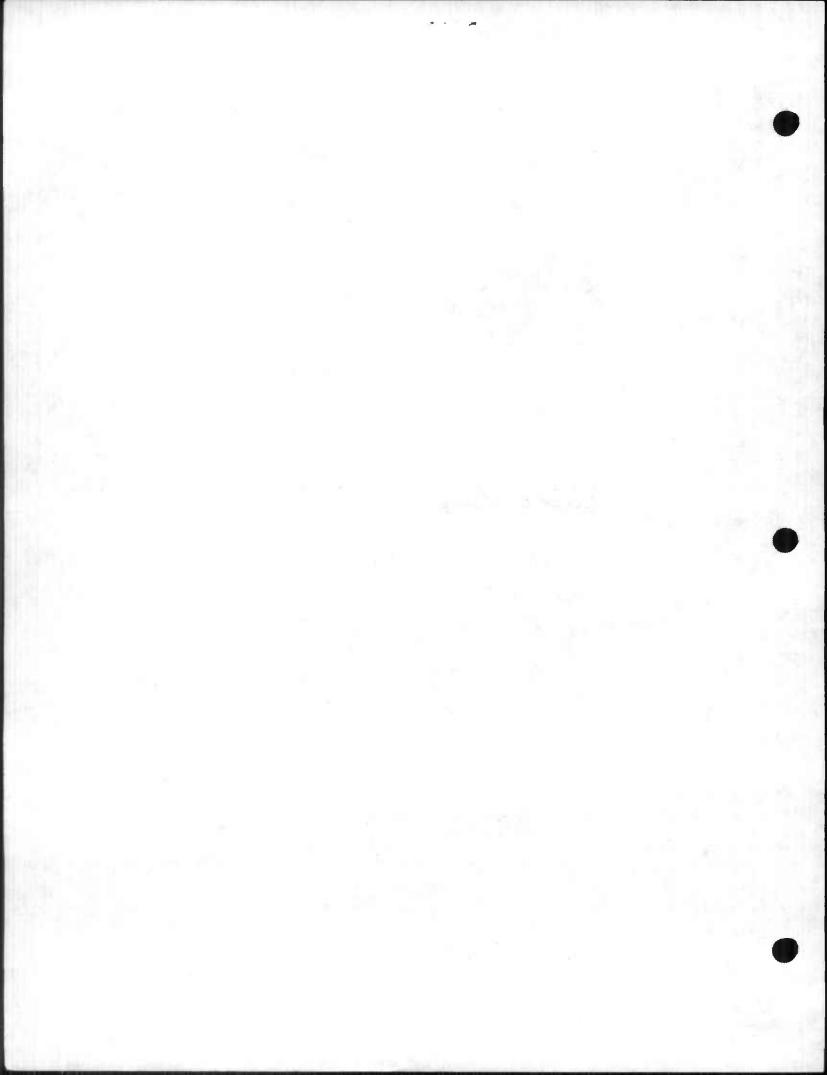
State of Maryland / Department of Health and Mental Hygiene 00 37307

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Physician /Medical	Louise	Anna f	Reeves						NOVEM.	DER 24	12000	109AM
Examiner	4a Facility Name (If	not institution, gi	ve street and nu	imber)			4b. City, To	own, or Lo	cation of Deat	h 4c. County	of Death	
25	Stella	Maris	@ Merc	cy Hosp	ital		Balt		e	n/a	а	
Funeral	5. Sociel Security Nu		Sex	7. Age (In yrs. la		If Under 1 Yes		24 Hrs. Min.	8. Dete of Bir (Month, De	th iv. Year)	9. Birth	place (State or Foreign ntry)
Director	212-28-56	17	1□ M 20XF	69	Yrs.	Morning Dey			3-1-19	931	Mary	land
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eth with the Meryla 23a or 28a-f sho us be notified at rai Director	1 N. Ellw	ood Aver	nue				21224	1		USA		
8 25 2	11. Marital Status	ord me	12. Was Dec	edent Ever in U,S	6. 13. V	Was Decedent of Yes, specify Co	f Hispanic Or	rigin? (Spe	ecify Yes or No		ce - Ameri	can Indian,
efter des or flems referen		ed 2 Married		2 XNo		☐ Yes 2 🗷 N			, , , , , , ,		y: Whi	
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or He	20a. Method ot Disp			0.0	ace of Dispo	sition (Name of	olaca)		Date -	20c. Location	- City or T	own, State
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프 교육관광 .	21. Signature of Fun	neral Service Lice	ensee		22	. Name and Add	dress of Facil	ity Jos	eph N.	Zannin	o Jr.	Funeral Hm
De pe l'inge	Mar	01	211-			53 S. Co						and 21224
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Of Vital I Physician: The this certificate ral director, page 1: To Be Co	25. Was case reterre	ed to medical						e of Death	(Check only	oneStEllI	7 11)	ARIS AT MEA
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	Accident	investigation	on				☐ Yes 2☐	No No				
Vision Attended of the by the tiffical	3 Suicide	6 Could not determined	d 28e. Plac	a of Injury - At hou	me, farm, str	eet, fectory, offic	<b>&gt;</b> 0		28t. Location City or To	(Street and Num	ber or Ru	ral Route Number,
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111	30. Name end addre	ss of person who	completed cau	se of death (Item	23a) (Type.	Print)	0.1		115	MEDIL	D A	017,0000
/ PIV	DAVID	Rica	bER9	301	154	PAUL	P/ 1	BAL	timo	RE M	Di	24,2000
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Registrar	NOV 2 7	2000	Seren	1 19	do	2 4						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 609 Month **Physician** ETTA MAE ROSS November 19, 2000 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner Baltimore City Hospital General 5. Social Security Number H Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 10/22/1920 If Undar 1 Yaar Birthplace (Steta or Foreign County)
 MD . 7. Aga (In yrs. last birthday) Days 1 ☐ M 2 🕸 F 212 22 7963 80 Yrs. Director Usual Rasidence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 1 Yas 2 No BALTIMORE Director MD. 10e, Street and Number 10f. Zip Code 10g. Citizan of What Country? 23a or 3 21223 116 S. AMITY ST. USA Peges 1 end 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or itema 23. Funeral 12. Was Decedant Evar in U.S. Armed Forces? 1 Yas 2 No If Yas, Giva Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian Black, Whita, atc. AFRO 1 Nevar Married 2 Married 1 □ Yas 2 No Specify: AMERICAN þ 3 ☐ Widowed 4 ☐ Bivorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER HOME 10 0 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumema) unknown unknown 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) permit. Peges 1 and 2 s Department of Health ar Important: if Nem 27 is any Injury or other trau MARTHA DORSEY 106 N. AMITY ST. BALTO. MD. Saltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from Stata 11/22/2000 LANSDOWNE, MD. MT. ZION CEM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Service Licensee CECL A. 22. Nama and Addrass of Facility
ESTEP BROTHERS FUNERAL HOME P.A. ESTEP eul 1300 EUTAW PL. BALTO. MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaen Onsat and Death **Physician** Immedieta Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Physician/Medical Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate causa. Entar Underlying Cause (Disaasa or Injury that initiated events rasulting in death) Last use as the burisi-tran Vascular eral Box 68760 Dua to (or as a consequence of) rema P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed page 1 Yes 2 PNo 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa rafarred to medical 26. Pleca of Death (Check only ona) Hospital: 15 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) To 1 Yes 2® No edical Certification: 27. Manper of Death 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Naturel 5 Pending invastigetion s after death. 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Routa Number, City or Town, Steta) 3 ☐ Suicide 6 ☐ Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a Hospital 1 Cortifying Physician: To the best of my knowledga, deeth occurred at the time, date end place, end dua to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifier completely (Check only one) To the P 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifian baath (Item 23a) (Type, Print) General Badi 31. Data filed (Month 32. Registrar's Signatura State Registrar



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

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þ		ried 2 Married	Armed Force  1 Yas 2 in If Yas, Giva Yaar or Date:	S) No	1. (60)	′as, speci ]Yas 2		lispanic Origin? (S an, Maxican, Puar Specify:	to Rican, efc.)	Specif.	ck, Whita,			
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once.	21. Signature of Pt	D C	T		VA	IGHN	C.	SS of Facility  GREENE	FUNE	PAL SER	VICE			
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29b. Signeture end title of certifier

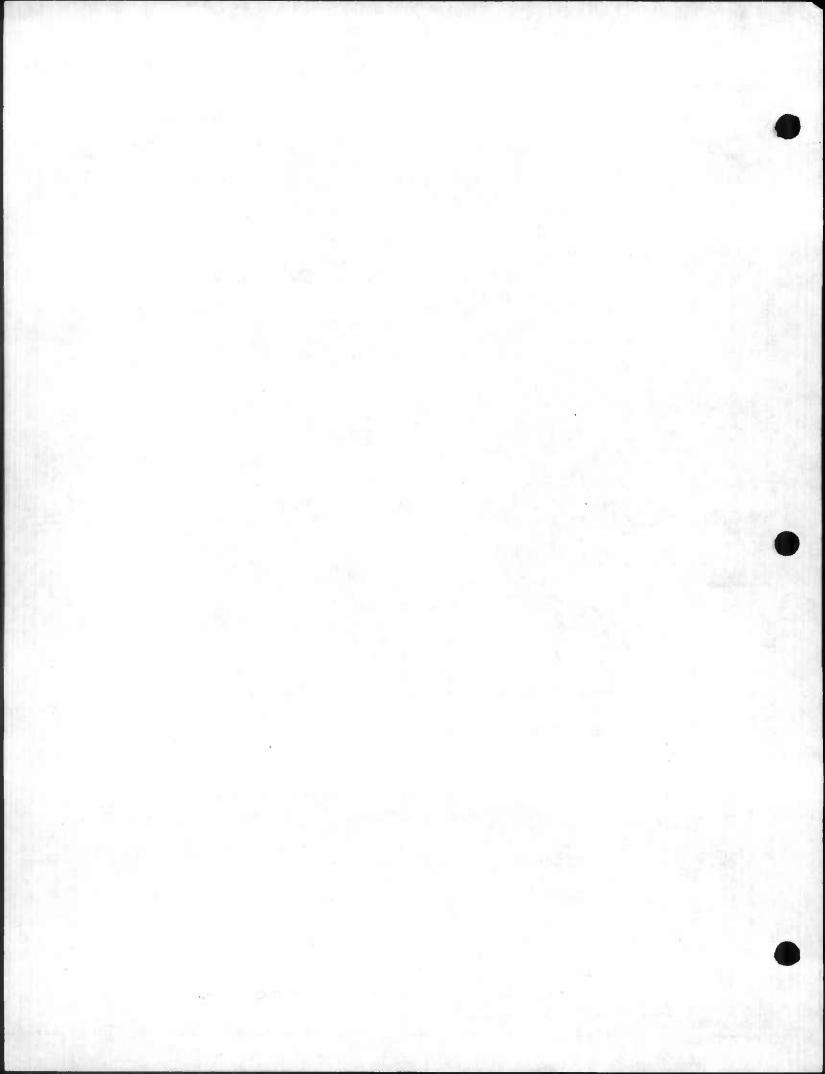
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29c. License number 29d. Date signed (Month, Day, Year) OCME NOVEMBER 24 2000

1/1 30. Neme and address of person who completed cause of deeth (Item 25a) (Type, Print)

> 32. Registrer's Signature
> 32. Registrer's Signature
> 32. Registrer's Signature oaks!

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 12 per fh G789 11/27/00 yf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 23 2000 7:6 AM 11 JEAN, J, SCOTT /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE 3202 HARFORD ROAD If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthpiace (State or Foreign Country) **Funeral** Days Months 1□M 2☑F MARYLAND Director 70 217-24-1496 The Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 □XYas 2 □ No Director BALTIMORE 28e-f MD 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 23a or 21205-USA 2617 BERYL AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian Black, Whita, atc. 72 hours after 1 Yes 2 No If Yes, Giva Year or Dates: 1 Never Married 2 Merried i Hygiene. other than "natural", or the vent, the Medical Examin 1 Vas 2 No Specify: NO À Specify: **BLACK** 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE FAMILIES DOMESTIC 12 . Pages 1 and 2 should be flied w timent of Health and Merital Hygler tant: If Nem 27 is marked other to fury or other traumatic event, the 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be ALMA ROY ROBERT WHITTINGTON 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 2617 BERYL AVENUE BALTIMORE MD 21205 JOSEPH L SCOTT SR /HUSBAND 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Data 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) 11/30/2000 WOODLAWN, MD WOODLAWN CEMETERY 21. Signature of Funeral Service Loss 22. Nama and Addrass of Facility MARSHALL W. JONES JR. FUNERAL HOME P.A. 4101 Edmondson Avenue Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Batween Onset and Death **Physician** ung, Cancer Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) USB 88 signed by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tos 2 No 3 Probably 4 Unknown à 24b. Ware autopsy findings eveilable prior to complation of causa of death? Completed 24a. Was an autopsy performed? page 2 certificate 1 Yes 2 12 No 1 ☐ Yes 28 No funeral director. Be 25. Was casa refar 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Dother (Specify) Son's home Certification: To 1 Yes 2 No this 27. Manner of Death 28b. Tima of Injury 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending invastigation after deeth. 1 Yas 2 No 2 Accident 6 ☐ Could not be e Hospital or Atter 24 hours after der Funeral Director pleasity filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Box 68760. P.O. Division of Vital Records, Attending Physician:

Baltimore, Maryland 21215-0020

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) end manner stated. 29a. Cartified (Check only one) 29b. Signature and title of certif 29c. License number 29d. Data signed (Month, Day, Year) who completed cause of ath (Item 23a) (Type, Print) 49 10

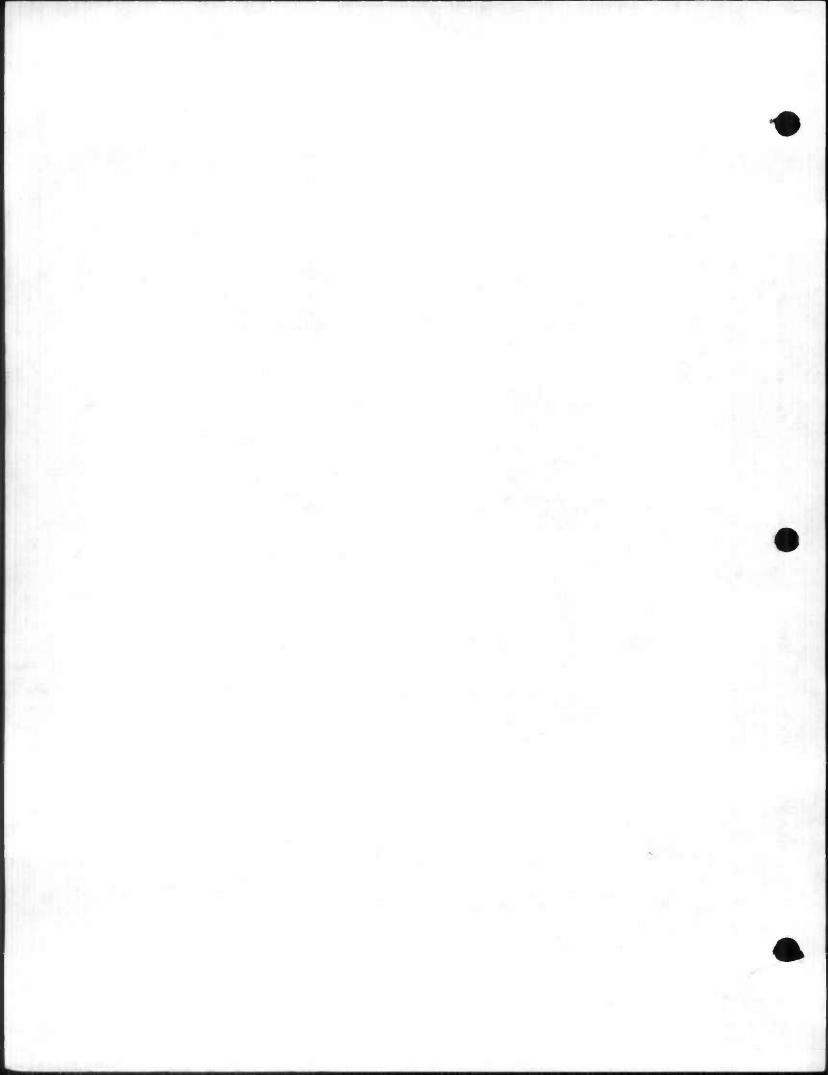
State Registrar

Medical

31. Data filed (Month, Vay, Year) NOV 2

32. Registrar's Signati

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/Med		Olivia G				D-71)				Month NOVEMBE		5,2000	5:31P.M.
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Funeral Director		5. Social Security Number 218 36-8464		7. Age (In yrs. last	t birthday) Yrs.	tf Under 1 Ye Months De	ear eys	If Under 2 Hours		8. Date of Biri (Month, Da			rthplace (State or Foreign country)
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pemit. Pege Department Important: If any Injury or once.		21. Signeture of Funaral Service	ce Licensee	31	A.		Fu	inera1	. Но	me of L Lansdow			
Physician /Medical Examiner	ler	23a. Part1. Entar the disease, shock, or heart leilure. Li Immediate Cause (Finel disease or condition resulting in death)	or complications that clist only ona cause on a	Due to (or an	19:	e	dyling	, such as o	-	UT (		3	Approximate Interval Between Onset and Death
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State Registrar

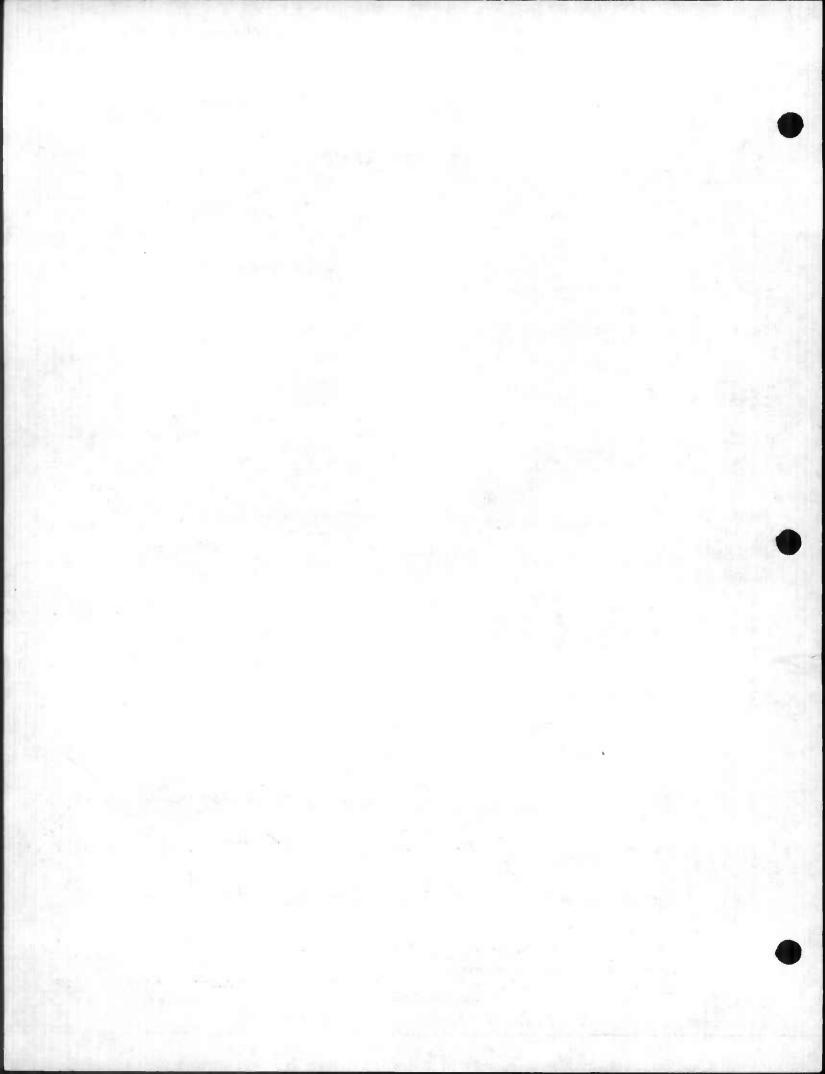
31. Date find (Month, Day, Year)

DHMH 16 Rev 6/95

32. Registrer's Signeture

111 Penn Street, Baltimore, Maryland 21201

ORIGINAL



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth NAPU 1005AH NOV 2000 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Deys 1□M 2 F Months 87 Maryland Yrs. 218-46-5901 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 No Yes 2 No 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 228 Stonecraft Rd. Apt. B 21229 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Charles Myers Mary 19e. Informent's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Halbert Stone / Son 228 Stonecraft Rd. Apt. B Baltimore, MD. 21229 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 11/29/00 Baltimore City Baltimore National Cemetery 21. Signature of Funeral Service License 22. Neme end Address of Fecility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. leath. Do not enter the mode of dying, such as cardiac or respiretory errest, Intervel Between Onset end Death Immediete Cause (Finel disease or condition resulting in deeth) Due to (or es e consequence of) EM phy Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): Due to (or as a consequence of): 23b. Did tobacco use contributa to the causa of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 2 DNO No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

by

Completed

**Funeral** 

**Director** 

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permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Meeting Marie Hygiene.
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Director: Aft
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Physician/Medicai þ Completed Be 2 edical Certification:

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Registrar

29a. Certifier

that initieted events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth

1 Neturel
2 Accident 28b. Time of 28d. Describe how injury occurred tnjury et Work? 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year) NOU 25, 2000

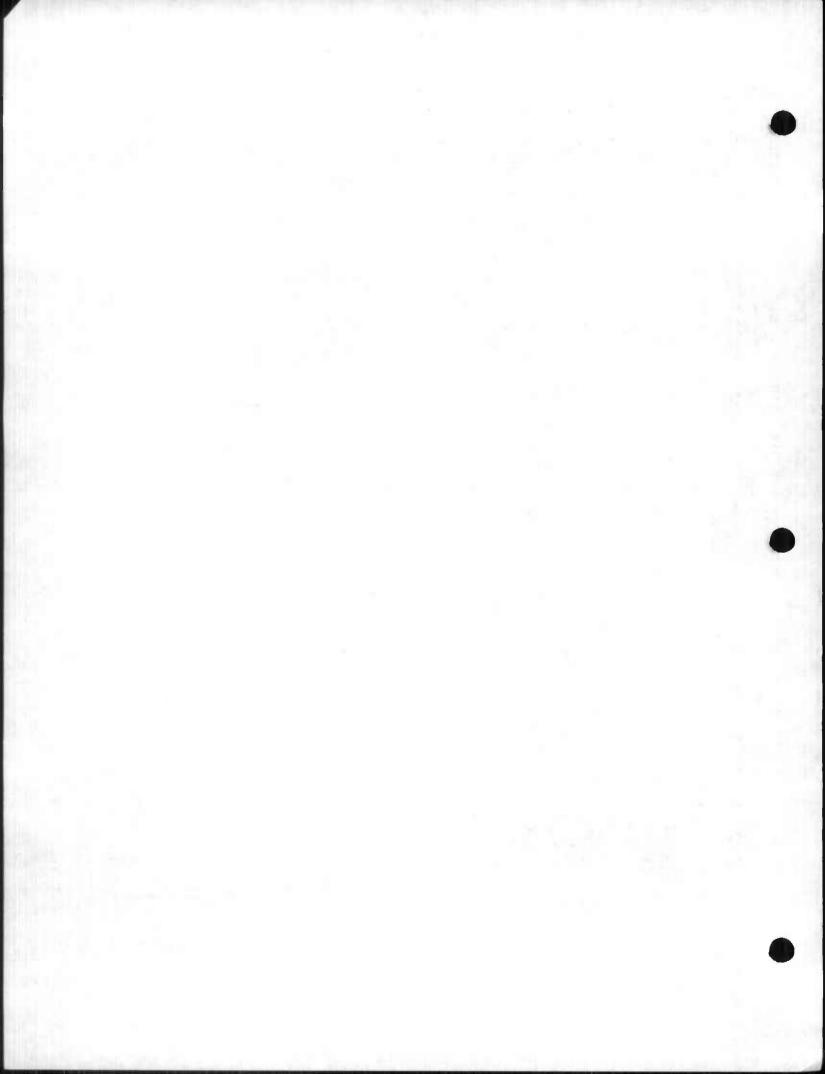
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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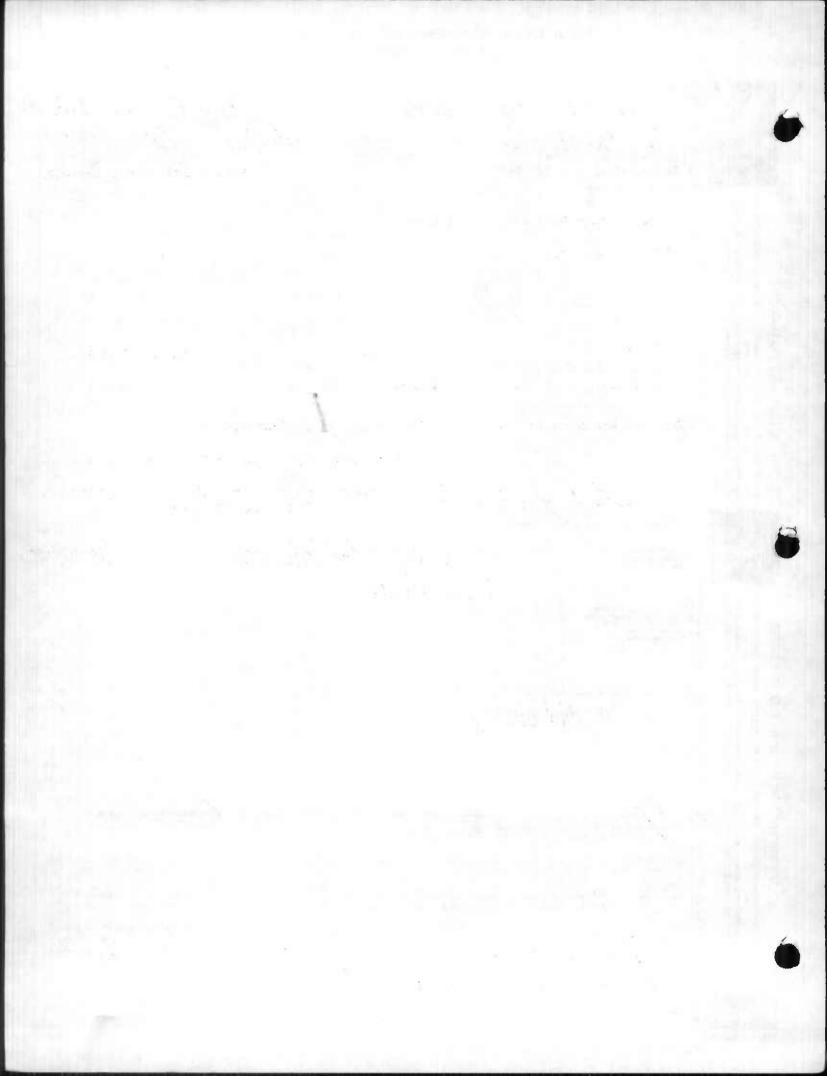
31. Date filed (Month, Dey, Year) NOV 2 7 2000

32. Registrer's Signeture



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and and	-	I Residence o	10b. County		10c. City	, Town or L	ocation						10d	. Inside City Limits
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To the Hospital or within 24 hours after To the Funeral Dir. completely filled in Medical Cert	29e.	Certifier (Check only one)	1☐ Certifying F 2☑ Medical Ex	Physician: To the besis aminer: On the besis end menner	of examinet	wledge, dee ion end/or l	th occurre	d et the ti	me, date end pla opinion, deeth oc	ce, end due to th curred et the tim	e ceuse(s e, date end	) end menne d placa, end	r es stet due to th	ed. ne cause(s)
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month I. Camilla Schell 3:45 PM November 20, 2000 4a. Facility Name (If not institution, give street end number) 4c. County of Deeth 4b. City, Town, or Locetion of Death Community If Under Hear Ketirement Catonsville har lestown Himore If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1□ M 2√ F 85 219-20-6264 Yrs. AUG. 12, 1915 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2X No Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 719 Maiden Choice Lane 21228 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No if Yes, Give Year or Datas: 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Wilhelm Kluth Blanche Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dan Schell - son 526 6th Street, S. E., Washington DC 20003 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 11/2560 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery Baltimore, Md. 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 21. Signature of Funeral Service Licenses 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Finei tumor of small intestine disease or condition resulting in death) Carcinoid Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings aveilable prior to completion of ceuse of death? 24a. Wes en eutopsy performed?

**Physician** /Medical Examiner

physician

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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tha Maryland

filed within 72 hours after death

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Baltimore, Maryland

/Medical

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To the Hospital o within 24 hours aft To the Funerel Di complately filled in

Division of Vital Records, P.O. Box 68760

Physician/Medical by Completed Be

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Registrar

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Devaturai

29a. Cartifian

2 Accident 3 Sulcide 4 - Homicide

5 Pending investigation

6 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Spacify)

1 ☐ Yas 2 ☐ No

28. Piace of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 28d. Describe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

2 1No

1 Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

28c. Injury at Work?

November 20,2000

1 ☐ Yes 2 ☐ No

Assisted

Living

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) Stone Maiden

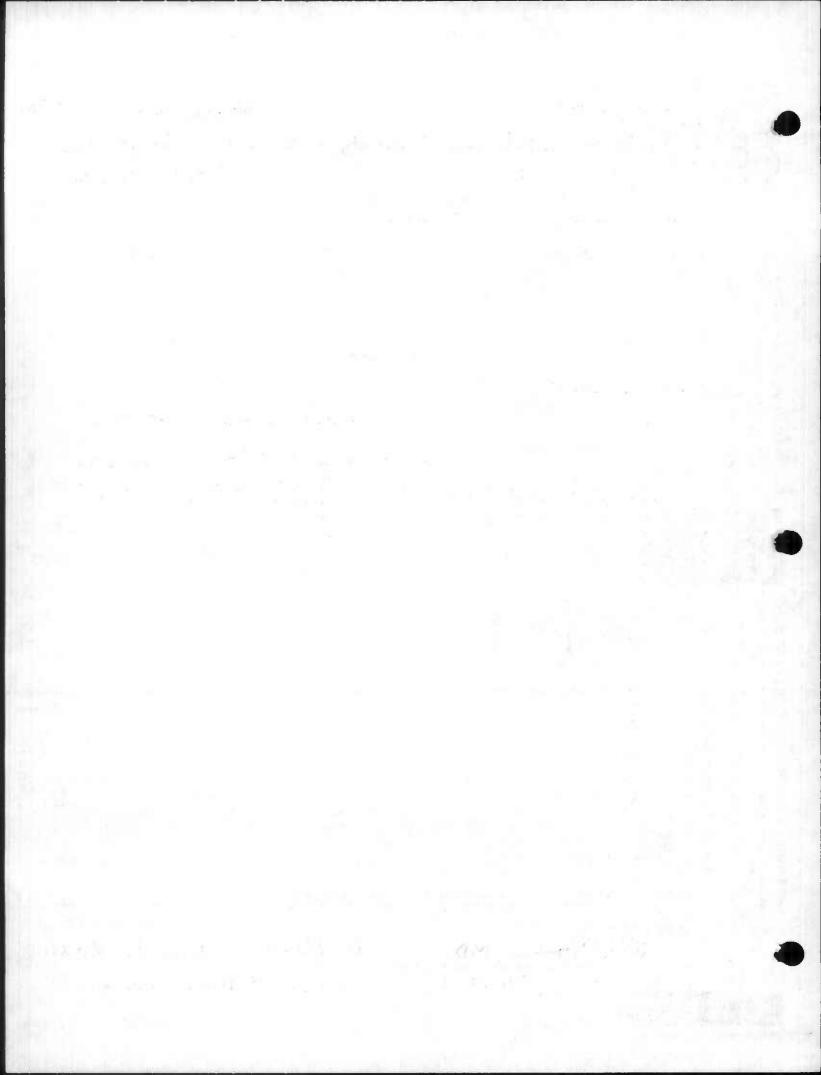
31. Date filed (Month, Day, Year) NOV 2 7 2000

29b. Signature and title of certifier

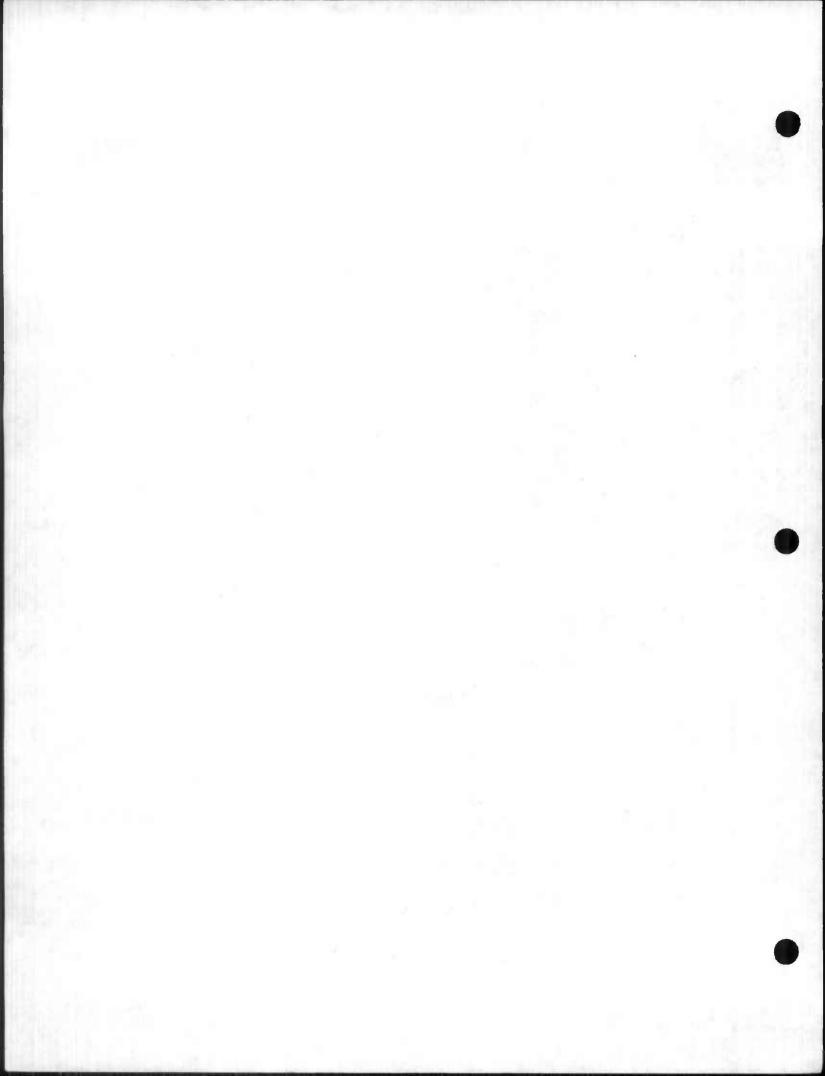
32. Registrar's Signature

Choice Lane Baltimore, MD 21228

**DHMH 16 Ray 6/95** 



State of Maryland / Department of Health and Mental Hygiene amend item 20b per fh G789 11/27/00 yf Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** SPENCER 2000 JAMES 22 6:25 AM /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deal Examiner Center ospita LIMOLE Hanbon If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Months Deys Hours Min. 10 M 20 F 249-10-7252 Yrs. Director 08/09/1916 Douth Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or thema 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Director more 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral O filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Race -American Indien 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Maryland 21215-0020 If Yes, Give Year or Detes: Specify: Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) To. 0 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 2 should be fill end Mental H Be Commit. Pages 1 and 2 sho.
Department of Health and M.
Important II from 27 is mo-19e. Informent's Name/Reletionship (Type, Print) Brother 19b. Mailing Address (Street end Number or Rural te Number, City or Town, Stete, Zip Code) 06 Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of permetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 11/29/2000 Hill turn of Funeral Service Licen 22. Name and Address of Eacility 23a Part. Enter the miseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, and or heart failure. List only one cause on each line. 2 Approximete intervel Between Onset end Death **Physician** Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical Kerpiratany 41 days Examiner Due to (or es a consequence of): Physician/Medical Examiner postab. Intertinal as the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury and Sigmoic Box 68760. been signed by the attending physician should be detached for use as the buria Ulceration thet initieted events resulting in death) Lest Due to (or es a consequence of): o Seemal Pheumonva Aspiroutron P.O. | Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? certificate has 2 10 No 1 Yes 1 Yes 2□ No Physician: eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 npatient Certification: To 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28c. Injury et Work? or Attending F 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C edical 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner steled. 29e. Certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier Cowhen MD phydisce D0005631 allende usha 30. Neme and address of person who completed cause of death (Item 234) (Type, Print) MUSUNURU 31. Dete filed (Month, Dey, Yeer) 32. Registra/s Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year **Physician** SMITH NOVEMBER 25 9:55 AM 2000 /Medical 4e Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL CENTER BALTIMORE BAYVIEW HOPKINS JOHNS WA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) 8. Dete of Birth (Month, Day, Year) August 24, 1924 6. Sex 5. Social Security Number **Funeral** Deys Hours Months 403-22-4217 1 M 2 DAF 76 Yrs. IL **Director** Usual Residence of Decedent 10a. Sfete 10c. City, Town or Location 10d. Inside City Limits 10b. County MD N/A Baltimore City MXYas 2 No Director Hygiane, or thems 23e or 28e-f. other than "netural", or items 23e or 28e-f. ont, the Medical Examiner must be notified 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 1431 Fast Clement Street 21230 United States Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, etc. 12. Wes Decedent Ever in U,S.
Armed Forces? Navy NEVY Server 2 No Nevy If Yes, Give Year or Detas: WWII, 42–46 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 35 No Specify: White Specify: p 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementery/Secondary (0-12) College (1-4or 5+) Electrician Service 10 0 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be till ment of Health and Mental H ants: if itsm 27 is marked oth lary or other traumatic even Be Adelaide Fillippini Charles D. Smith 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19s. Informant's Name/Relationship (Type, Print) Alfredda Hurst-Smith / Daughter 712 Spoon Court, Arnold Maryland 21012 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, Steta cremetory or other plece) por Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or Cedar Hill Cemetery, November 29, 2000 Baltimore Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Aveneu, Baltimore Maryland 21230 23a. Part1. Enter the disaese, or complications that cause the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervat Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical SEPSIS Examine Due to (or es a consequence of): Examine PNEUMONIA the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760 EMPHYSEMA Physician/Medical Dua to (or as a consequenca of): 58 for use as signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown requires that ISCHEMIC CARDIOMYOPATHY by 24b. Were autopsy findings evailable prior to completion of causa of death? been si 24a. Wes en eutopsy performed? Completed nis certificate has b 2 200 1 Yes 2 No Physician: 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1) Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of Injury 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Certification: After Attending 1 Neturel 5 Pending investigation death. 1 Yes 2 No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide after 6 To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end mennar stated. 29e. Certifier edical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of conti-November 25, 2000 21000 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) 4940 21224. MURTUZA AVE BALTIMORE EASTERN MD

DHMH 16 Rev 6/95

State

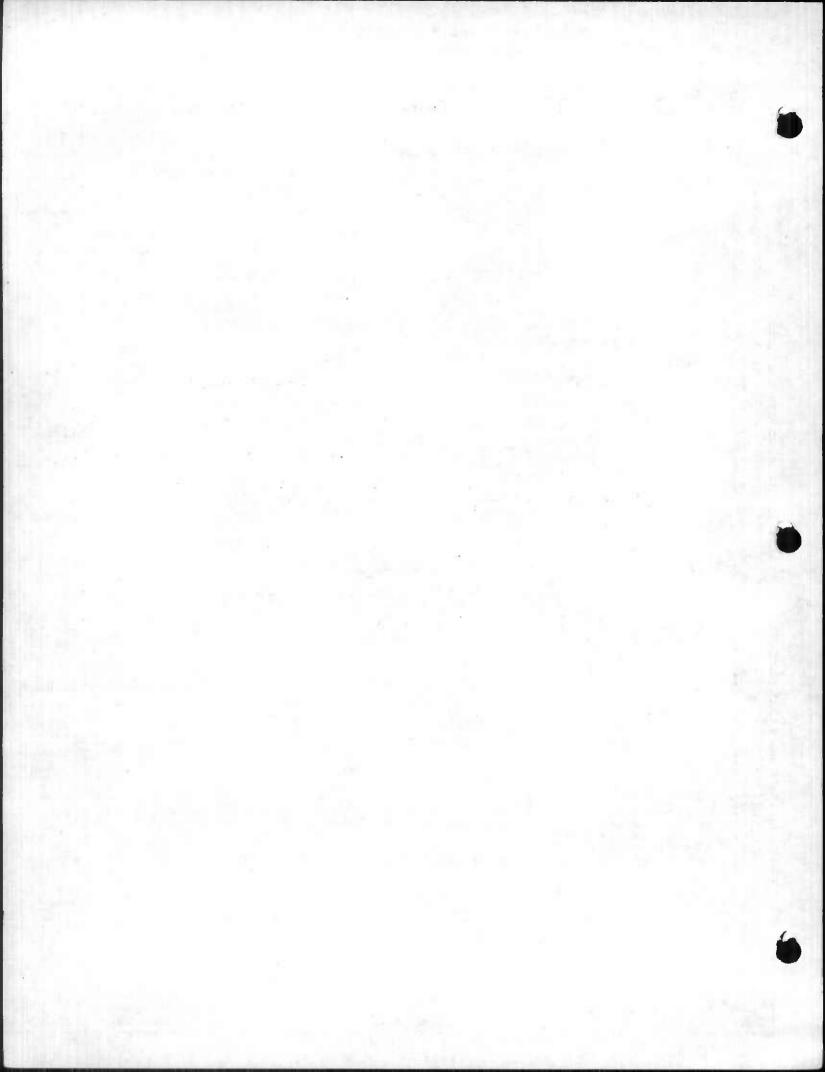
Registrar

31. Date filed (Month, Day, Year)

NOV 27

ORIGINAL

32. Registrer's Signeture

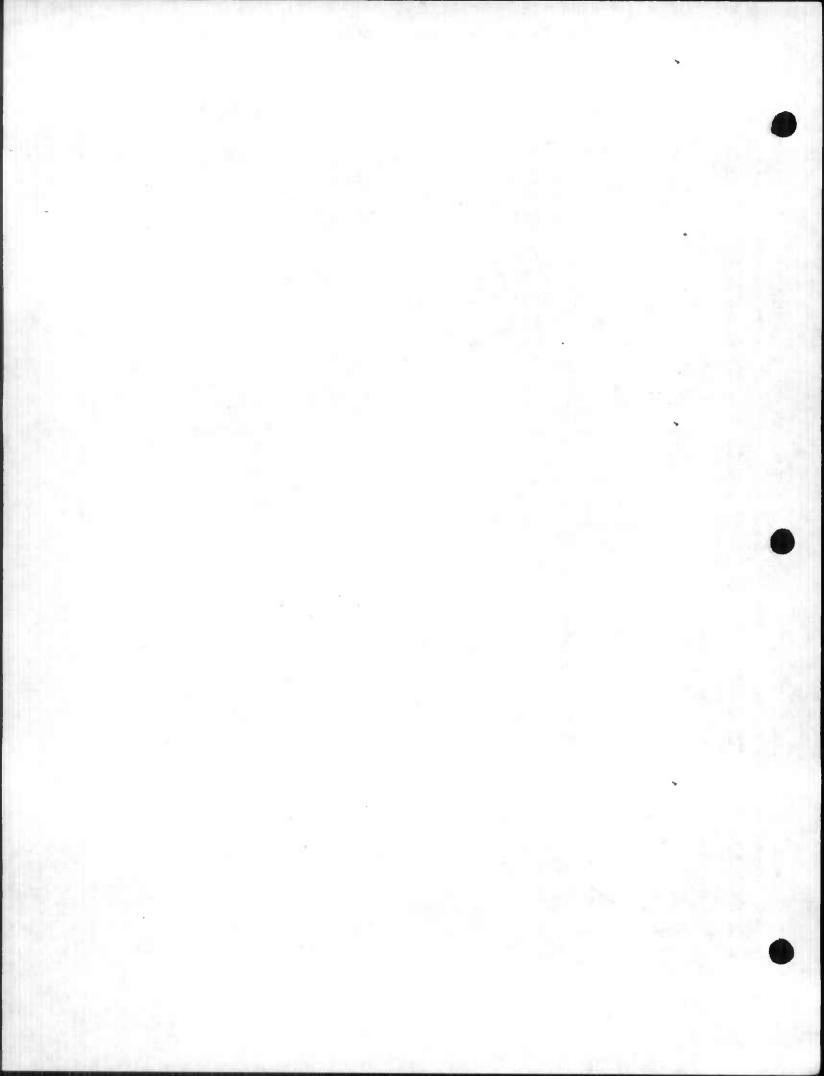


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Yaar **Physician** Willa A. Slimmer 9:30 AM NOVEMBER 23, 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Saint Joseph Medical Center 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sax Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2X F Months Days Hours Min Yrs. 79 233-30-2139 **Director** Nov. 6, 1921 WV. Usual Rasidance of Dacedant the Maryland t∩a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or Hems 23a or 28a-f show the Medical Examiner must be notified at 28a-f show Md. Baltimore Woodlawn 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5930 Montgomery St 21207 USA Funeral death 12. Was Decedent Evar in U.S. Armad Forces? 1 ☐ Yas 2 Ø No If Yas, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Introcramt: if them 27 is marked other than "natural", or item any Injury or other traumatic event, the Mental Process 1 □ Navar Married 2 □ Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 N Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) 12 yrs. Cashier Food 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be W. Stokes Rosa Martin 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph White Sr. bro-in-law 7802 Wynbrook Rd. Baltimore Md. 21224 20a. Method of Disposition

1 Burial 2 Cramation 3 Ramoval from Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata Nov. 28 SYKESVILLE Lakeview Cem. 4 □ Donation 5 □ Othar (Specify) 2000 21. Signatura of FunarahSarvice Licensar 22. Nama and Addrass of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part1. Ental the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or bear failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting in daeth) CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Examiner Dua to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be asscuted Sequantially list conditions, if any, laading to Immadiata cause. Enter Undarfying Cause (Disease or Injury that initiated avents resulting in daath) Last use as the burial-tran Dua to (or as a consequence of): Box 68760, attending physician Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? signed by I 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown END STAGE RENAL DISEASE p of Vital Records, 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy page 2 should Be Completed CEREBROVASCULAR ACCIDENT this certificate has 1 Yas 20 No 1 Yas 2 No Hoppini or Attending Physician: 24 Pour after death.
Funeral Director: After this certification in by the funeral director; p 25. Wes case referred to medicel 26. Piece of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yas 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Division 1 SCNatural 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28e. Place of fnjury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide within 24 hours To the Fuheral Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) To the 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of cort D-37254 23 00 30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print) 21204 MARYLAND DRIVE. TOWSON. OSLER LIM M.D. 7601 BOON P. 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State NOV 2 7 2000 Registrar



#### Ple

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					/ Depa	artmer	nt of I		and N	Mental Hy	63	0	37319
1. Decedent's Nan	ne (First, Middle, L.	ast)			-	timodi		Doda		2. Dete of De			3. Time of Death
ROBERT	BRUCE S	SHAW								November November	Day er 22.	2000	4:46 AM
4a Facility Name (			mber)					4b. City, To	wn, or L	ocation of Death	1	ty of Dea	
History History	naritan H							Balt	-imo	ro	N/		
5. Social Security I		Sex	7. Aga	(in yrs. last	birthday)	If Unde	r 1 Yeer	If Under	24 Hrs.	Date of Bid	4		thplace (Stete or Foreign
212-48-	7703	1⊠M 2□F		53	Yrs.	Months	Days	Hours	Min.	Jan. 1	y, Year) 8 194	7 0	Md.
Usual Residence	of Decedent									100	, 171		1101
10e. Stata	10b. County			10c. City, T	own or Lo	cation							10d. Inside City Limits
Md.	Baltim	nore		Ba1	timo	re							1 ☐ Yes 2 No
10e. Street and Nu	ımber	Tara .				10f. ZI	p Code	-			f Whet C	ountry?	
1814 Dui	nwoody Cr						21:	234		2		USA	
11. Marital Stetus		12. Was Deci	edent E	var in U,S.	13.	Was Dece	dent of I	lispanic Ori	igin? (Sp	pecify Yes or No			erican Indian,
1 Nevar Mar	riad 2 Married	Armed Fo	2 2 No							o Rican, etc.)		lack, Whi	ta, atc.
3 Widowed	_ 44	If Yes, Gir Yeer or D	/6			1 🗆 Yes	SKI No	Specify:			Spec	-	Nhite
	15. Decedent's E		20	1	6a. Dece	dent's Usu	al Occu	pation	4 04	d in a	16b. Kind of		
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12	J. 100.7 (0 1.2)	00090 (		1	eale	r					An	tiqu	es
17. Father's Neme	(First, Middle, Las	it)						18. Mothe	er's Nem	ne (First, Middle,			
Jake		Shaw						Ruth		Christin	ne R	osen	stein
19a. Informant's N	lame/Relationship	(Type, Print)			19b. Maili	ng Addres	s (Stree	end Number	er or Ru	rel Route Numbe	er, City or Tow	n, Stete.	Zip Code)
Mrs. Jan	ne T. Sha	w/wife			1814	Duny	rood:	v Cr.	Ba	ltimore.	Md 2	1234	
20a. Method of Dis		,		20b. Plece	e of Dispo	osition (Ne	me of		- DG.	Dete			Town, State
	S Cremetion 3 l 5 ☐ Othar (Spec		State						1	1 100 100	_		
21. Signature of F				Hill:	top S	ervi 2. Nama a	ce (	orp.	tv 1	1/28/00	Towso	n , Mo	
SEE	alex	0,64	7	-	R	uck T	ows	on Fun	iera.	1 Home,			
23a. Part1. Enter shock, or her	tha disaasa, or con ert failure. List onl				Do not ent	ter tha mo	de of dy	ing, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
tmmediate Cause diseese or conditi- resulting in deeth)	on	a. /	en	tric	ula	er	+	ibri	lla	fion			10 minute
		· A	cul	e (or m	My	LOCA	rd	ial	in	farct	ron		1 hour.
Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of	mmediate ertylng r Injury	. C	er	ona ona	14	quence of)	lean	+	di	sease	2		yrs.
thet initiated event resulting in death)	Last	l d	D	ue to (or ag	a cytisec	(uence of)							
Part II Other steel	diagnt gooditte	annerile seine er d	anth h.	mat as a let-	o in the	un da el cia -	001100	una la flara i		20h Bid	tohanco una	ontella d	e to the cause of death?
Pert II. Other signi		contributing to di	sath but	not rasum	g in the d	inderlying	cause g	ven in Parti		112	/		Probably 4 Unknown
										perfo	en eutopsy ormad?		Were autopsy findings availabla prior to completion of cause of death?
				0						10	Yes 2 No		1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

**Funeral** 

Director

than "natural", or hams 23s or 28s-f show

permit. Pages 1 and 2 should be filled will Depositment of Health and Meetal Pygiern Important: If itsm 27 is marked other the anny inclury or other traumatic event, the once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Be Completed by

after death.

Director: After this certificata has been signed by the attending physician and if in by the funeral director, page 2 ahould be detached for use as the burial-tran To the Hospital or Attending Physician: Medical Certification: To

Division of Vital Records, P.O. Box 68760,

Pert II. Other significant condi 25. Was case referred to medical axaminar? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatiant 2 FR/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending invastigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suiclde 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and manner es stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and manner es stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and manner es stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and manner es stated. 29e. Certifier

29c. License number

D-17992

29d. Dete signed (Month, Dey, Year)

11-22-00

State Registrar

NOV 2 7 2000

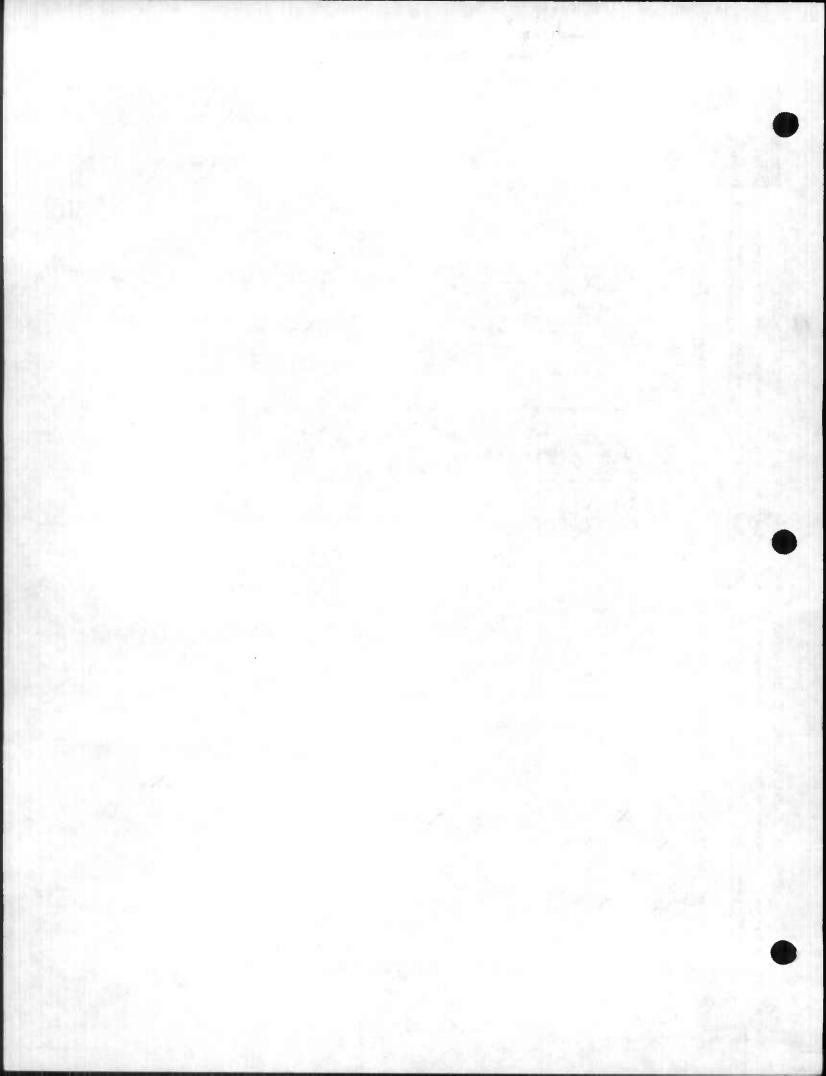
29b. Signature and title of certifier

30. Name and address of person who completed cause of deeth (Item 23a) (Typa, Print)

1312 Goucher B. Lvd Towson Md 21286

31. Date filed (Month, Dey, Year)

32. Registrar's Signature

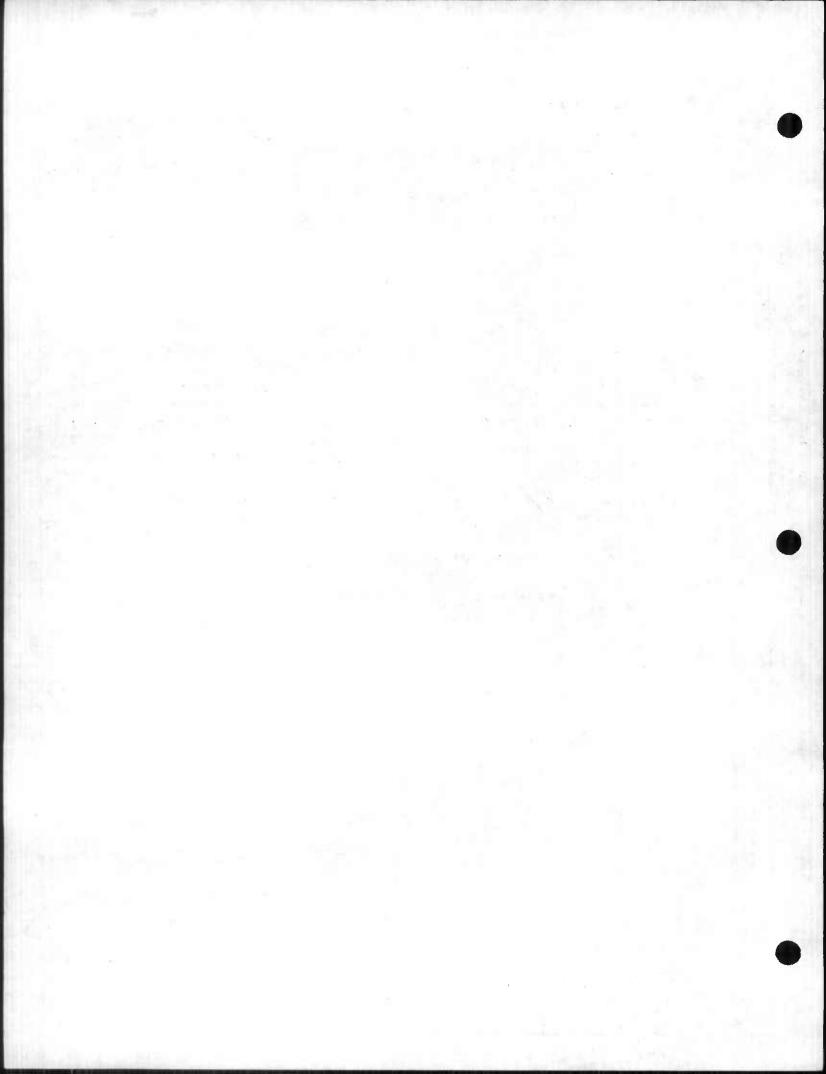


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Mildred Dolores							Month	Dey	Year	
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	□M 2½F		rs. Months	Days	Hours	Min.	July 19	7. Year)	Penn	ylvani
Usual Residence of Decedent			1				2			2
10a. State 10b. County	1	Oc. City, Town	or Location						10d	Inside City Li
Md. Balti	more	T	owson							1□Yes 2⊠
10e. Street and Number			10f. Z	ip Code				10g. Citizen of V	Vhat Country	?
206 Wilden Driv	re			2	1286	100		U.	S.A.	
11. Meritel Stetus  1 Never Married 2 Married	12. Was Decedent Eve Armed Forces?	ar in U,S.	13. Was Dace If Yes, sp	edent of Hecify Cuba	ispanic Origin, Mexican	in? (Spe Puerto	ecify Yas or No- Rican, etc.)	14. Raci Blec	e - American k, Whita, ato	
1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yas, Give			2 🗆 No				Specify		
3€ Widowed 4 Divorced	Yeer or Detes:							400 160 1 400		ite
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17. Fathar's Nema (First, Middle, Last)		0	upervi	501	18. Mothe	r's Neme		Maiden Sumam		y Admi
William McF	adden					Mary				
19a. Informent's Name/Ralationship (T)		19b.	Meiling Addres	ss (Street				er, City or Town,	State. Zip C	ode)
Mr. James E. Stoke			214 Mole					Maryla		
20a. Method of Disposition		20b. Plece of	Disposition (Na	ame of		-	Dete	20c. Location -		
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Cause (Diseese or injury that initiated events	с.								1	
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25. Wes case raferred to medical					26. Place	of Deat	1 Check only o			res 2LINO
ayaminer?	Hospitel: 1 □ Inpatient	2 ☐ ER/Out	petient 3 C	Oth			n (Check only o		er (Specify)	
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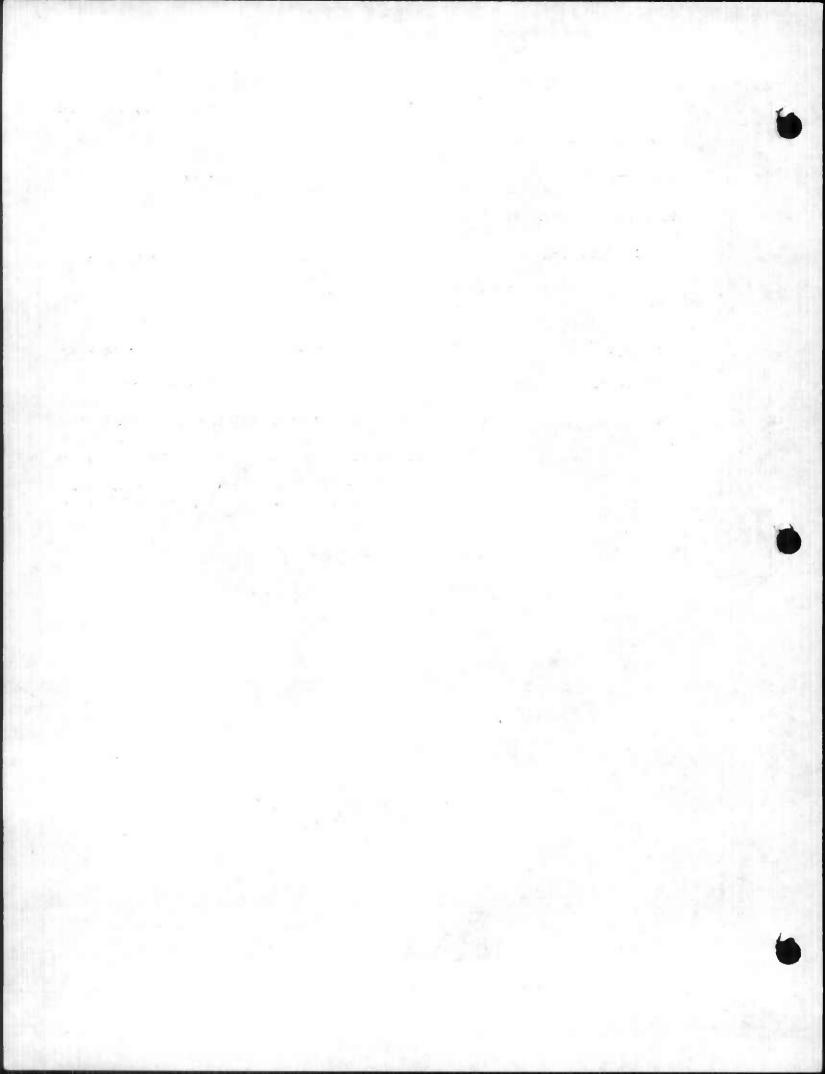
State Registrar DHMH 16 Rev 6/95

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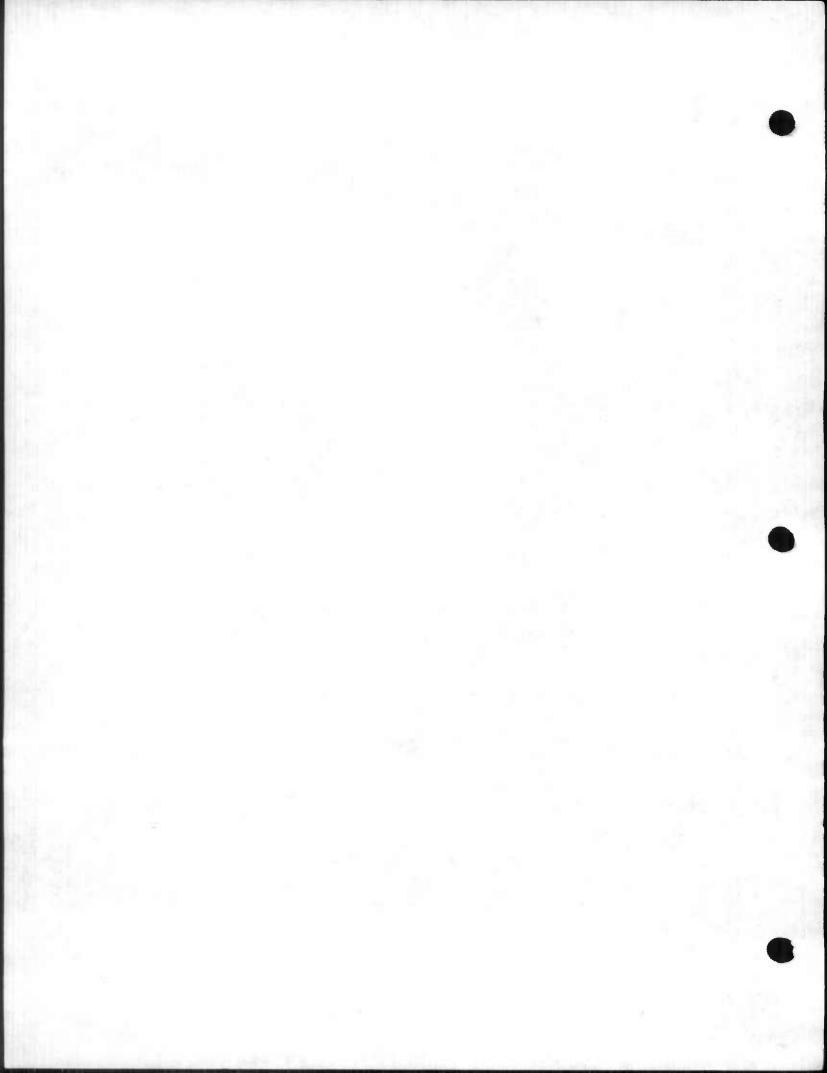
State of Maryland / Department of Health and Mental Hygiene ( ) 2729

				Certific	cate of	Death	R	eg. No.	01	061
ysician 1. 0	Decedent's Neme (First, Mic	dia, Last) Rober	t	N. S	Schopp	ert	2. Date of Dear Month	Day	Yeer	Time of Death
ical iner ^{4a}	Facility Name (If not institut	ion, give street and numb	per)			4b. City, Town, or	Novemb Location of Death	4c. County	of Death	1:50 AM
	Riverview Nu				- 1 1 //	Essex			ltimore	
	Social Security Number 216-16-2427 Jel Residence of Decedent	6. Sex 7.	Age (in yrs. la	Yrs. Mon	nder 1 Year oths Days				9. Birthplece Country) Maryl	(State or Foreig
108	. Stete 10b. Coun	y altimore	10c. City,	Town or Location		Rosedale				nside City Limits
5	. Street and Number	archiore		140	Tin Onda	Nosedate		Og. Citizen of V		
Funeral Dir	5810 East	Avenue		100	. Zip Code	21206	5		ed Stat	
-	Maritel Status  1 □ Never Merried 2 □ M.  353Widowed 4 □ Divorce	If Yes Give	es?			Hispanic Origin? (Spen, Mexicen, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Reci	e - Americen I ck, White, etc.	ndien,
	15. Deced (Specify only high	ent's Educetion lest grade completed)		16a. Decedent's (Give kind o	Usuel Occu	pation during most of wo	rking	16b. Kind of Bu	usiness/Industr	У
E	lementary/Secondary (0-12 8 Years	College (1-4	lor 5+)			hecker		Long	gshorem	an
17.	Fether's Name (First, Middl	e, Last)		4 1.0		18. Mother's Ne	me (First, Middle, i	Maiden Sumam	ne)	
	Clyde T. Sc	hoppert					Rebecca	Higgins	5	15115
19	a. Informant's Name/Relatio	nship (Type, Pnint)				t end Number or R				ie)
	Robert Schop	pert (Son)				Avenue I				1236
208	. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  Donetion 5 ☐ Other		ate ce	ace of Disposition metery, cremetory timore	or other pla		Date 27/2000	20c. Location - Balti		_{State} Maryland
See if a cau	a. Pert1. Enter the disease, shock, or heart failure. Li mediate Cause (Final eese or condition ulting in death)  quentially list conditions, ny, laading to immediate use. Enter Underlying use (Disease or Injury t initiated evants ulting in death) Lest  t II. Other significant condi	CON b. VE c. DEE d.	Due to (or Due to (or Due to (or	as a consequence  CULA es e consequence  EIN as a consequenca	2 TER 3 of):   R 3 of): 7 M 4 of):	Y DIS FIB ROME	RILLAT BOSIS	Dibacco use con	Interior of the	oroximate prival Batween set and Death set a
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Detelduco Person 25.	Was case referred to meet	ৰ্ম				26. Placa of De	ath (Check only or			
	examiner?	Hospital:	patient 2 E	R/Outpatient 3[	DOA	ther: 4 Nursing	Homa 5 ☐ Rasid	ence 6 Oth	er (Specify)	
27.	Manner of Death  1 D Matural 5 Pend 2 Accident inves	28e. Date of (Month, stigation	Injury Dey Year)	28b. Time of Injury M	28c. Inje We 1 [	ury at ork?	28d. Describe h	ow injury occur	red	
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27. 27. 29. 29. 29. 29. 29. 29. 29. 29. 29. 29	a. Certifier 1 Certify (Check only one) 1 Medica	ring Physician: To the bas at Examiner: On the bas end manne	is of examinati	rledga, deeth occu on and/or investig	rred at the lation, in my	ime, date and plac opinion, death occ	e, end due to tha c urred at tha time, o	euse(s) and ma late end plece,	anner as state and due to the	d. cause(s)
	. Signature and title of certi	07/	100		29c. Licer	se number		29d. Date signe	d (Month, Day	Year)
/	Kama	Hank	ar	, ND	Do	0481	146	11-2	2-	00
30.	Name and address of person Rama Shanker				Neck	Road Ba	altimore,	Maryla	and 21	221
State 31.	Dete filed (Month, Dey, Yes	(r) 6 32 Bag	ister's Signal	ire spor	es.					



State of Maryland / Department of Health and Mental Hygiene \(\cap \)

					Cert	ificate of I	Death	Re	g. No.		1066	
Physici		Decedent'a Neme (First, Middle, Last     ANNA	it)		SILVER	STEIN		2. Dele of Deelt Month Novemb	Day	Yaer 2000	3. Time of Death	
/Medic Examin		4a Facility Nama (If not Institution, give	e street and number)			- 14	lb. City, Town, or L		4c. County		10.30	
Exami	lei	Sinai Hospital					Baltimor	e		N/	'A	
Funeral Director		5. Social Security Number 6. S 219–56–3612	ex 7. Age	e (In yrs. la	est birthday) Yrs.	If Undar 1 Yaar Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEP.4,19	Year)		ace (State or Fore	
ซ		Usuel Residence of Decedent						001 01/11	7.2.2		. 112	
show the		10a. State 10b. County		10c. City,	, Town or Loca	ation		10d. Inside City Limits				
N THE	cto	MD BALTIN	ORE		BALTIM	ORE					1 □ Yes 2 🕅 1	
80.0	Directo	10e. Street and Number				10f. Zip Code		10	g. Citizan of	What Countr	у?	
23a	ira.	8 BRETON HILL R					21208		U.S.			
af, or ham Examiner	by Funeral	11. Marital Stetus  1 □ Never Merried 2 □ Married  3 □ X Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Detes:	The state of the s		as Decedent of H Yes, specify Cuba □ Yes 21, No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)		ce - Amarica ck, White, el		
72 ho nattur fical	Completed	15. Decedent's Ed (Specify only highest gra			16a. Decede	ent's Usuel Occup	etion during most of work	ring	6b. Kind of B	lusiness/indu	istry	
- 58	함	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO	O NOT use retired	)	king				
A Barbar	Co	12			OWNER/	OPERATOR		WOMEN'S RETAIL CLOTHIN				
S T T T T T T T T T T T T T T T T T T T	Be	17. Father's Name (First, Middle, Last)			tipoman.			e (First, Middle, M	leiden Sumer			
Merica	2	MORRIS	н.		HERTZB		IDA				HN	
hand Tis m		19e. Intormant's Neme/Reletionship (I					end Number or Rui ROAD - 1				Code)	
Healt ther		20a. Method of Disposition				ilion (Neme of	I NOAD - I		Oc. Location		on State	
0 = 0		1 Burial 2 □ Cremetion 3 □		ca	metery, creme	etory or other pled	1					
oluny .		4 □ Donation 5 □ Other (Specif)  21. Signature of Funeral Service Licen		HEBR		NG MEN C	EMETERY ]	11/19/00	MOOE	LAWN,	MD	
Physician /Medical		2.1a. Pen 1/2 Enter the disease, or compands, or head teilure. List only tellure the course (Finel			Do not enler		ERSTOWN I				Approximele Intervel Between Onset end Dealh	
Examiner		disease or condition resulting in death)	e. Perforat							1		
	Jer				a consequ	obstruct	ion >	_				
be executed ician and burial-transit	Examiner	Sequentially list conditions	D.		as a consequ		.IOII	1	1			
an al		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury					10	1 6	le	MAN	>	
t e	edical	thei initieted events resulting in death) Last	0	Due to (or	as a conseque	ence of):	- Louis Av	APPROVED BY	REDICAL ESA	MINER		
0 8	5								-			
e attendin ed for use	an		d.			300						
9 8	Physician/	Pert II. Other significant conditions co	entribuling to death bu	it not resul	lting in the und	derlying cause giv	en in Pert I.	23b. Did tol	pacco use co	ontribute to	the cause of dear	
6 6		COPD						1 🗆 Ye	s 210 No	3 Prob	ably 4 ☐ Unkno	
been signed I	Completed by	Hypothyroidism						24a. Wes er perform	eutopsy	ava	re autopsy tinding ilable prior to apletion ot cause	
00 (1	DE L								/	of d	leath?	
pa								1 ☐ Ye	s 2 2 No	10	Yes 2□ No	
this certificate he ral director, page	Be	25. Wes case reterred to medical examiner?	Hospitel:		/	all post Oth	or.	th (Check only one				
	. To	1  Yes 2 No  27. Menner of Death	1 🗆 Inpatier		R/Outpatient 28b. Time of	3LI DOM	4 LI Nursing H	ome 5 Reside			)	
iffer death.  Strector: After in by the fune	Certification:	1 Naturel 2 Accident 3 Suicide 4 Homicide  5 Pending investigetion 6 Could not be detarmined	28e. Pleca of Inju	Ury - Al hor (Specify)	Injury Incerta ma, farm, sirae	et, fectory, office	Yes 2 □ No	Pt. s/p e bowel per 28f. Location (Str City or Town Sinai Hos	nema v forati set and Num State)	with s ion ber or Rure!	Route Number,	
within 24 hours of the Funeral I completely filled	alc	29e. Certifier 1 Certifying Phy	ysician: To the best o				-		*			
Eur Petaly	edicai		iner: On the basis of and menner stel	examinelia	on end/or inve	estigation, in my o	pinion, death occur	red et lhe time, da	le end placa,	and due to	the cause(s)	
Mithin To the	Me	29b. Signeture and title of certifier	0	1,6		29c. Licens	e number	29	d. Dete signe	ed (Month, D	ley, Year)	
> 10		> dedenlyts	ort			DOG	50693	A	0110144	hor 2	2. 2000	
00	-	30. Name and address of person who o	completed cause of de	eth (Item	23e) (Tuna D							
)		ALDEN G. PEOPLE	J. MM 2	LL() (	N. Bel	relen A	we, Ba	thin ore.	mn	2127	5	
Sta	te	31. Dete filed (Month, Day, Year)	32. Registre									
		NOW 0 7 2000	the hand of	14	1.	a al 1						



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer Simon Seidman 3:15 AM November 22 2000 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Northwest Rondallstown Baltimore Hospital If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Devs | Hours | Min. | (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 1X M 2□ F 214-30-3416 Yrs. AUG.8,1922 POLAND Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4735 BYRON ROAD 21208 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 2 Merried 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) FURRIER FUR 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) **ABRAHAM** SEIDMAN ZELDA (UNKNOWN) 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DOROTHY SEIDMAN / WIFE 4735 BYRON ROAD - BALTIMORE, MD 21208 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete BALTIMORE HEBREW CEMETERY 11/24/00 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death

**Physician** /Medical Examiner

Pages 1 and 2 should be filed within 72 hours shar nent of Health and Mental Hygians.
ant! if Nem 27 is marked other than "natural", or he

Baltimore, Maryland 21215-0020

**Physician** 

/Medical

**Examiner** 

10a. Stete

**Funeral** 

Director

a 23a or 28a-f show must be notified at

Director

Funeral

by

Completed

Be

2

**burial-tran** 

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, use as the 8 page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

tmmediete Cause (Fine) diseese or condition resulting in deeth)	e. Cerebra	vascular A	Accident		days
rosuling in dealiny	Due to (	or as a consequence of	of):		
Sequentially list conditions, if any, leeding to immediate	b. Due to (	or es e consequence d	N):		
cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest	c. Due to (	or es e consequence o	f):		
Toolding in death, cost	d				
Pert II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	g cause given in Pert I.	23b. Did tobacco use co	ontribute to the cause of death
End Stage Renal	Failure, con	onay Artery	Dizerse,	1 ☐ Yes 2 ☐ No	3 Probably 4 ⊠nknow
End Stage Renal Athred Fibrillation	_			24e. Wes en eutopsy performed?	24b. Were autopsy lindings aveilable prior to completion of cause of death?
				1 ☐ Yes 210 No	1 ☐ Yes 2 🗷 No
25. Was case referred to medical			26. Place of De	eeth (Check only one)	
axaminer? 1 Yes 2 XNo	Hospitel: 1 Chapatient 2	☐ ER/Outpetient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Ott	her (Specify)
27. Menner of Deeth  1	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work? 1 Yes 2 No	28d. Describe how injury occu	rred
3 Suicide 6 Could not be determined	28e. Plece of Injury - At the building, etc. (Special	nome, ferm, street, lect	ory, office	28f. Location (Street end Num. City or Town, State)	ber or Rurel Route Number,
29a. Certifier (Check only one) Certifying Physics Medical Example (Check only one)	ysician: To the best of my kniner: On the basis of examinend menner steted.	owledge, deeth occurre etion end/or Investigati	ed et the time, dete end plac on, in my opinion, deeth occ	e, end due to the cause(s) end m curred et the time, dete end place,	anner as stated. and due to the ceuse(s)
29b. Signeture end title of certifier	1	2	29c. License number	29d. Date signe	ed (Month, Day, Year)
0.11	11 .				

State Registrar

31. Dete liled (Month, Day, Year) NOV 2 7 2000

Christopher

Davis

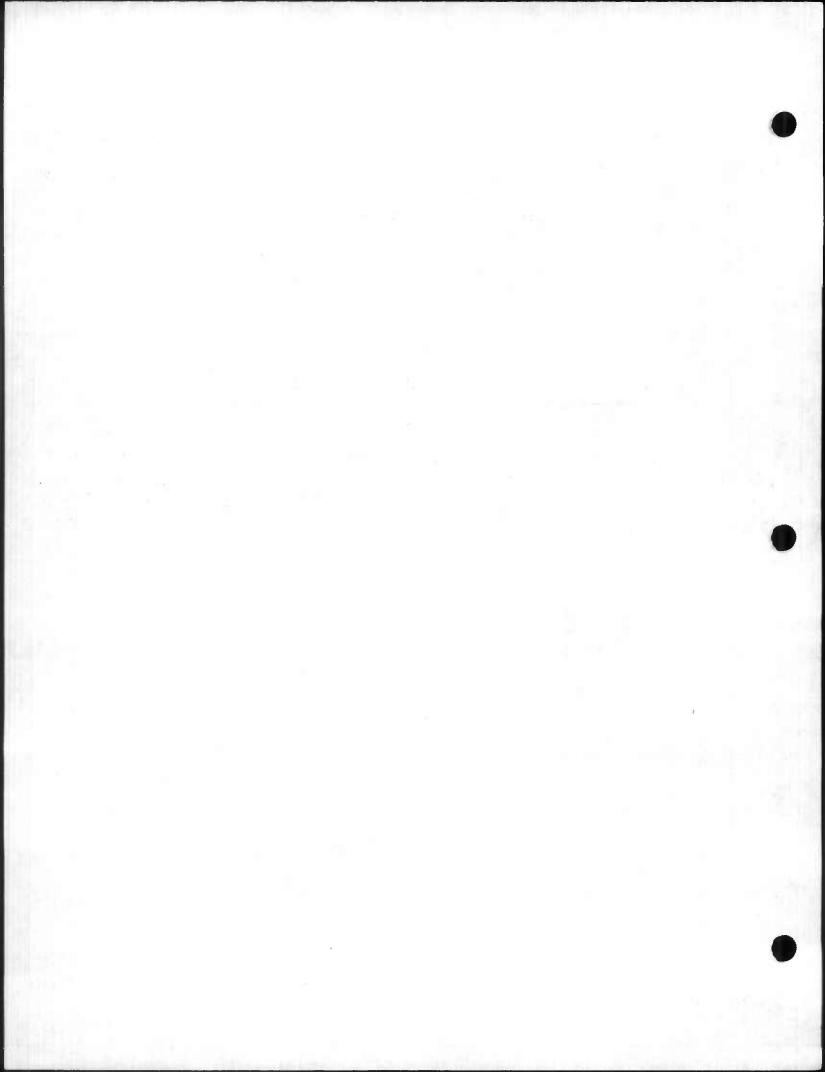
M.D.

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 00055609 2401 west Belvedere

November 22, 2000

Baltimore, Maryland 21215 Avenue

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 00 37324

			Certifica	ate of Death	7	Reg. No.	
Physician /Medical	1. Decedent's Name (First, Middle, I	- 11	era		2. Date of I Month	Dey	Year (1:45
Examiner	4a Facility Name (If not institution, g	ive street and number)	ic trospi	al B	own, or Location of De		
Funeral Director	5. Social Security Number 213–12–6367  Usual Residence of Decedent	Sex 1	Yrs Month		100	Birth Dey, Year) L9,1920	Birthplace (Stete or Forai Country)     MD
art show illind at	10e. State 10b. County	/A 10c. Ci	ty, Town or Location  BALTIMOR	E			10d. Inside City Limi
the or start aut be notified	10e. Street and Number 3718 BARTWOOD	ROAD	10f. i	Zip Code 2	1215	10g. Citizen of V	
af, or harre 23 Examiner must by Funeral	11. Marital Status  1 □ Never Married 2 🕅 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Evar in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		sedent of Hispanic Coecify Cuban, Mexicoecify Room Specify	origin? (Specify Yas or an, Puarto Rican, etc.) y:	No- 14. Race Blace Specify	a - American Indian, k, Whita, etc. : WHITE
ver then "natural, to the Medical. Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NOT BOOKKEEP	work done during mo usa retired)	ost of working	16b. Kind of Bu	siness/Industry
c event, the c o Be Co	17. Father's Neme (First, Middle, La: ISADORE	st)	STEINBER	18. Mot	her's Name (First, Midd		garbus
To a mark	19a. Informant's Name/Relationship VELLA STEINBE		19b. Mailing Addre	ess (Street end Num	ber or Rurel Route Nur D - BALTIM		Stete, Zip Code)
ant of Head It: If Nem 2 y or other	20a. Method of Disposition  1 💢 Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Contr	20b. F	Placa of Disposition (fi cemetery, cremetory of	lema of r other piece)	Date TERY 11/24	20c. Location -	City or Town, State TIMORE, MD
Departm Importan any injur 2005	21. Signature of Funeral Subsection	711	22. Name	and Address of Fac	SOL I	LEVINSON	& BROS., INC.
ysician	23a. Part1. Enter the dream, or co shock, or heart talling. List on	mplications that caused tha daat ly one cause on each line.					Approximete Interval Between Onset end Death
Medical kaminer	Immediete Cause (Final diseese or condition resulting in deeth)	8.	or es a consequence				5 days
een signed by the attending physician and hould be detached for use as the burial-transit sted by Physician.Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last	c. Cach	or as a consequence of as a consequence of as a consequence of as a consequence of a consequence of as a consequence of a con		rase.		
ed by the attend datached for us	Part II. Other eignificant conditions	contributing to death but not ras	sulting in the underlyin	g cause given in Par		ld tobacco use co	ntribute to the cause of deal
cate has been signed to page 2 should be date.						as en autopsy erformed?	24b. Were autopsy finding available prior to completion of cause of death?
certificate has b rector, page 2 s					11	Yes 2 No	1 ☐ Yes 2 ☐ No
海南 上	25. Was case referred to medical axaminer? 1  Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Dey Year)	BR/Outpatient 3 28b. Time of Injury	Other	Nursing Home 5 Re 28d. Descrit		
	2 Accident investigat 3 Suicida 6 Could not determine	be See Bless of lains. All	ome, farm, street, factify)	1 Yes 2	28f. Locatio	n (Street and Numb Town, Stete)	per or Rural Route Number,
within 24 hours after deat To the Funeral Director; completely filled in by the Medical Certifica	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my known arminer: On the basis of examine and manner stated.	owledge, death occurretion end/or investigati	ed et the time, date a	and placa, and due to to eath occurred et the time	he cause(s) end ma ne, dete and placa,	anner as stated. and due to the cause(s)
Within To the comp	29b. Signature and title of Cartifier	My mor	90	Doo53	200	29d. Date signe	d (Month, Dey, Year)
9	30. Name and address of person with PRISCITA 5		m 23a) (Type, Print)	, PLD L	airdak l	rosp, BA	Timore MD
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrar's Signa	ature				

Shayer Steinberg II Is 200 II:45om Levi and Gernard Brazante Brazante City

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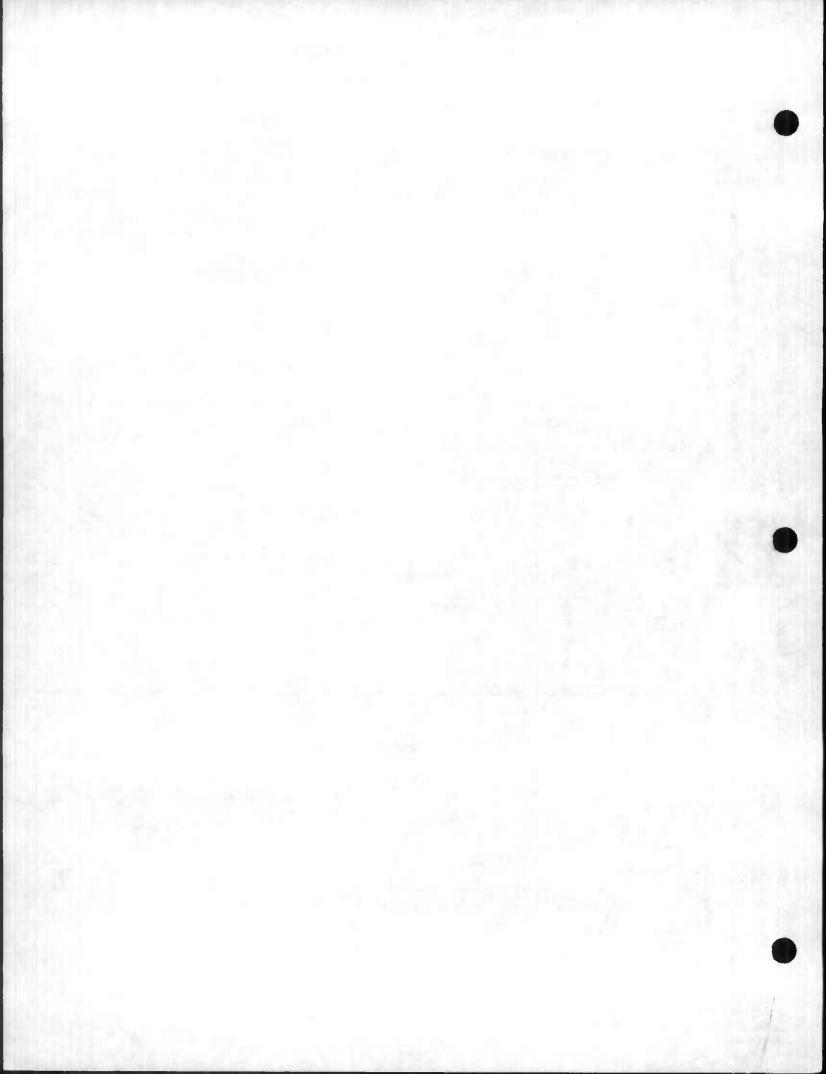
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Presente Sindle - Cat Hope - worder last the MA

State of Maryland / Department of Health and Mental Hygiene

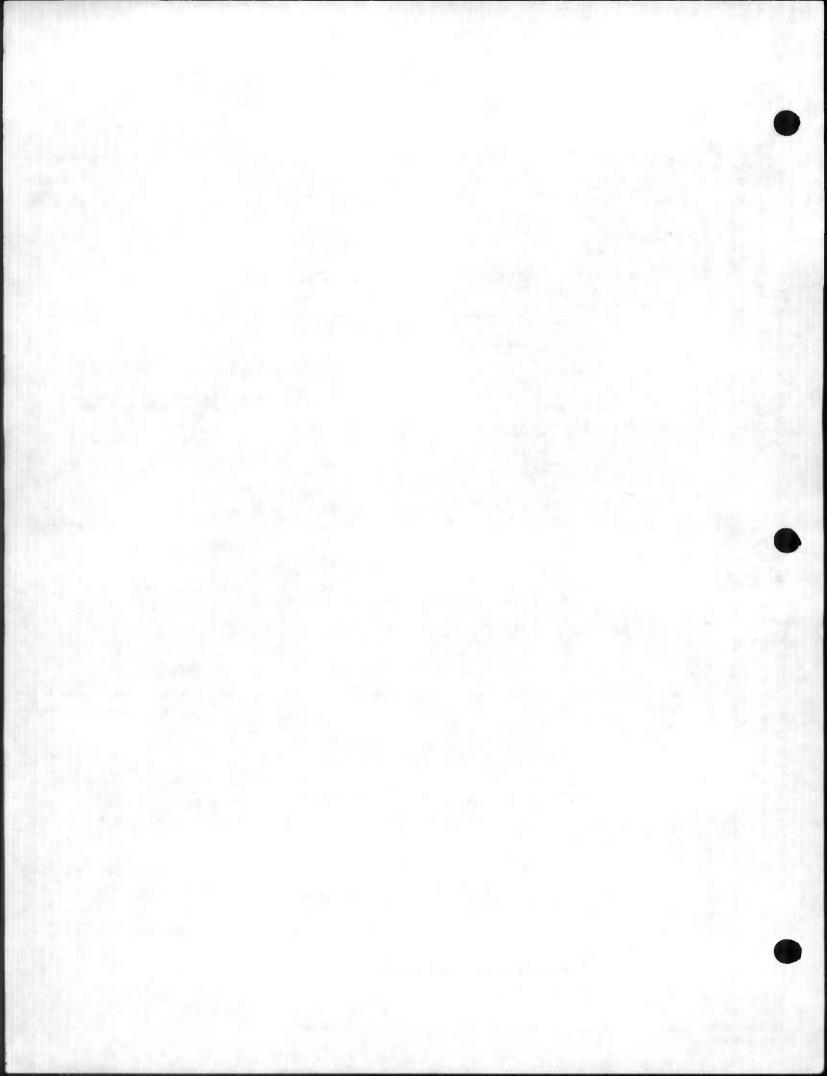
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ene	U	U	3	1	J	600	4

Gre	egory Sav	rage			Certificate of	of Death	Re	g. No.	01000			
		1. Decedent'e Neme (First, Middle, La	est)				2. Dete of Deelh Month		3. Time of Deeth			
	Physician /Medical	GREGURI	LOUIS SA	AVAGI	₹.		Novembe					
	Examiner	de Engille, Blame (Mant Institution of	re street end number)			4b. City, Town, or L		4c. County of E				
		University Hospi				Baltimor	e	N/A				
	Funeral Director	213-90-1164	Sex 7. Age (In yrs		hdey) If Under 1 Ye Months De		8. Date of Birth (Month, Dey, 06-13-	Year) 1977	Birthplace (State or Foreign Country) MD			
	pu .	Usuel Residence of Decedent  10a. Stete 10b. County	10e C	ity Town	or Location				10d. Inside City Limits			
	in the Maryle or 28s-f sho	MD NI/A			BALTIMO				tX Yes 2 □ No			
	sth with the Maryler 23s or 25s-f show		ON BLVD.		10f. Zip Cod	21230		t Country?				
21215-0020	72 hours efter deeth with the Manyland natural; or flems 23s or 28s-f show deal Examine must be notified at the dry NV Funeral Director	3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	J,S.	13. Wes Decedent If Yes, specify C	of Hispenic Origin? (S) Cuben, Mexican, Puerti No Specify:	pecify Yes or No- p Rican, etc.)		American Indien, White, etc. LACK			
5-0	ed within 72 hours ygiena. er than "natural", ft, me Medical Exi ft, me Medical Exi	15. Decedent's E (Specify only highest gr		16e.	Decedent's Usuel Oc (Give kind of work do	cupetion one during most of work	king	6b. Kind of Busin	ess/Industry			
121	within ena.	Elementery/Secondery (0-12)	College (1-4or 5+)			one during most of work tired)		DOODIN				
					LABORER	40 Newbode Name	a (Final Middle A	ROOFIN	G			
Maryland	Saby G					18. Mother's Nen	er's Neme (First, Middle, Meiden Sumeme)					
Z	should and Men marke surratic	GREGORY SAVAGE  19e. Informent's Neme/Reletionship	Time Print)	10h	Mailing Address /St	DEBR	A L. RAN		ste Zin Code)			
Ma	then treu	LATOYA MILES/FI		130.								
re,	Hee Hee	20a. Method of Disposition	20b.	Pleca of	Disposition (Name of	INGTON BLV		20c. Location - City				
Baltimore	permit. Pages Department of Important: If its any injury or o	1 Burial 2 Cremetion 3 4 Donetion 5 Other (Speci	(y) P	IETR(		1	1/28/200	O BALTO.	, MD.			
Bal	Departi Importu any Inje	21. Signature of Funerel Service Lice	1-4		JAMES	A MORTON	& SONS F	.H., INC	7			
		23a Part Enter the disease, or com	plications thet caused the dee one cause on each line.	th. Do n	ot enter the mode of	dying, such es cardiac	or respiretory arre	• 1110 - 2 1 2 1 ist,	Approximete Intervel Between			
V	Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	No	17.	De (	1 1	-Non	4	Onset end Deeth			
4	P # 5											
90,	ificeta be executed g physician and as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury the initiated events  Due to (or es e consequence of):  Due to (or es e consequence of):										
x 68760,	5 00	resulting in death) Llist	resuming in death) Laist									
Вох	attender for us								1			
P.0.	thet the death cent ed by the attendin detached for use.		contributing to death but not re	sulting in	the underlying cause	given in Part I.	23b. Did to	A-4	bute to the cause of death?  Probably 4 Unknown			
Vital Records,	v requires been sign should be						24e. Wes er perform		24b. Were autopsy findings available prior to completion of cause of death?			
Re	delan: The law certificate has breetor, page 2 s						North	s 2 No	1 Yes 2□ No			
ta	in: T	25 Was case referred to medical				26 Place of Des	th (Check only on		7100 25110			
<u>&gt;</u>		examiner?	Hospitel: 1 ☐ Inpatient 2.	J ER/Out	petient 3 DOA	Other:	ome 5 Reside		(Specify)			
100	g Physicar this neral di		28a. Date of Injury (Month, Pey Year)	28b. T		Injury at Work?	28d. Describe ho		4			
0	Attending or death.  ector: Aftal by the fune	1 Natural 5 Pending investigation	1/12/00	171		1 Yes 20 No	2050	ect of	Ue			
Division	tal or Attending P is after death.  In Director: After ted in by the funering Certification:	3 Suicide 6 Could not be determined	28e Plece of Injury - At I building, etc. (Spec	nome, fer	m, street, fectory, off	ica	28f. Location (Sti	reet end Number , Stete)	or Rural Route Number,			
	its after in led in Cert			20	ert		Harlen	- Ave/	Carey of:			
	he Hospital or Attending Physics 24 hours after death. In 24 hours after death. In Emeral Director: Attar this feath filled in by the funeral deathcal Certification: To	29e. Certifier 1 Certifying Pl	nysician: To the best of my kn miner; On the basis of examin- end menner steted.									
	Within 2	29b. Signature and title of certifier			29c. Lie	ense number	29	d. Dele signed (#	Month, Dey, Year)			
	.).	X O cat	of and		0.0	C.M.E.	I	Vovember	22,2000			
	2/	30. Name and address of person who	completed cause of deeth (Ite	m 23a) (		Street,Bal	timore.Ma	aryland 2	21201			
	State	31. Dete filed (Month, Day, Year)	32. Registrar's Sign	eture		0						
	Registrar	NOV 2 7	2000 Dener	no	13. M	market						



State of Maryland / Department of Health and Mental Hygiene 37326

						Cei	tificate	of	Death			Reg. No.		
		1. Decedent's Nam		nst)							2. Date of D Month	eath Day	Year	3. Tima of Death
	Physician	No. 3 Aug.	RHONDA	KEY SN	/ITH						NOVEM		2000	8:00 P.M.
	/Medical Examiner	4a Facility Name (	'If not institution, gir	ve street and n	umber)				4b. City, To	wn, or Lo	cation of Dea		nty of Death	
	Examine	111	BOUND ROL			P POAT	)		ABING	MOT		HARI	npn	
I		5. Social Security f		Sex	7. Age (In yrs. I		If Under 1		If Under		8. Date of B			place (State or Foreign
	Funeral			1 □ M 2 🔽 F	39	Yrs.		Days	Hours	Min.	11-10-	ay, Year)	Cou	place (State or Foreign intry) NY
	Director	122-54-0	0243	21	37				1		11-10-	1901		NI
	pu a	Usual Residence of	10b. County		10c City	, Town or Lo	cation							10d. Inside City Limits
	anyle	The state of		DEODD	100. 01.)									1 Yes 2 □ No
	No Maria	MD	пА	RFORD		JOPP	A TOWN							
	or 2	10e. Street and Nu					10f. Zip C					10g. Citizen	of What Cou	intry?
	ath with the Marylar 23a or 28a-f ahow ust be notified at rai Director	107 KE	YON COUR	Т			21	280.	5		USA			
	within 72 hours after death with the Maryland ene. "natural", or items 23e or 28e-1 show he Medical Examiner must be notified at empleted by Funeral Director	11. Marital Status		12. Was De Armed F	cedent Ever in U,	S. 13. \	Was Decede	nt of H	lispanic Ori	igin? (Spi	ecity Yes or N Rican, etc.)	0- 14. F	lace - Ameri	
0	or the	1 Never Man	ried 2 Married	1 Yes	2 No		1 □ Yes 2	-		1, 1 0010	DT A			
21215-0020	st', or tems Example in by Fune	3 Widowed	4 Divorced	If Yes, G Year or			ILIYes ≱i	FINO	Specify:			Spe	city: L	BLACK
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	hours a uneral if ity filled cal Ce	29a. Cartifier	1 Certifying Pl	hysician: To th	a best of my know	vledga, death	occurred at	the tir	me, date ar	d place.	and dua to the	a cause(s) and	mannar as	stated.
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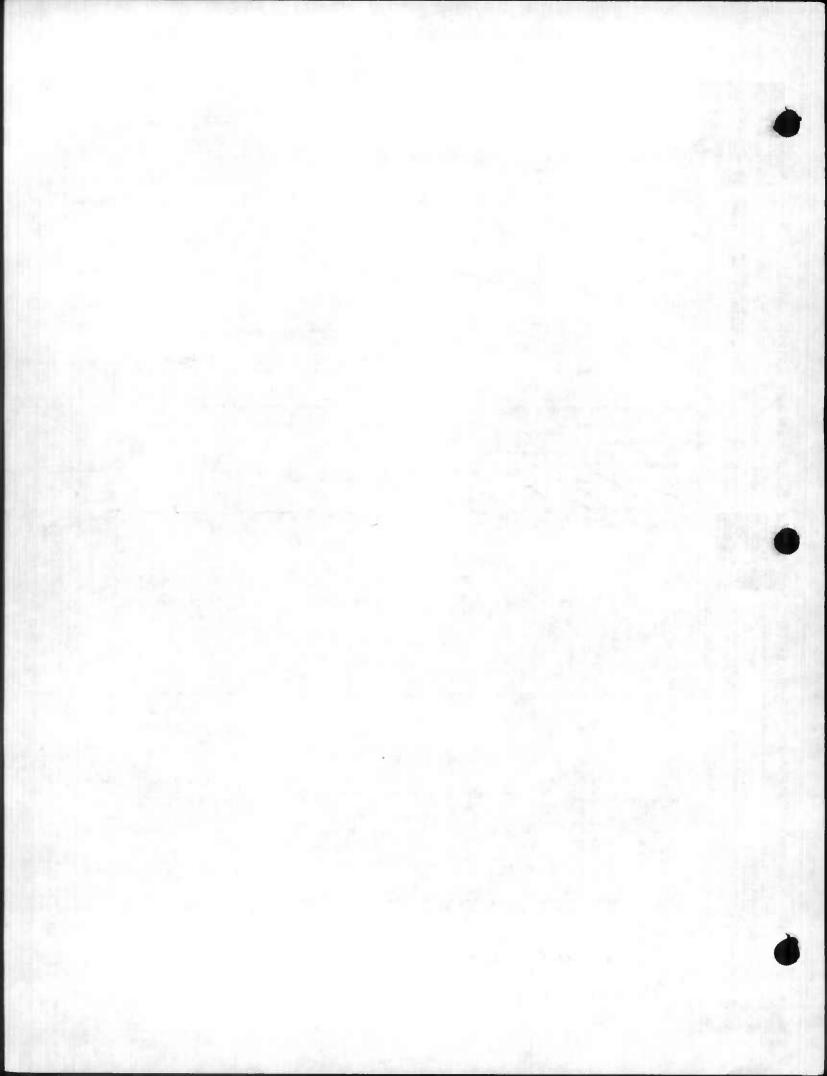


State of Maryland / Department of Health and Mental Hygiene

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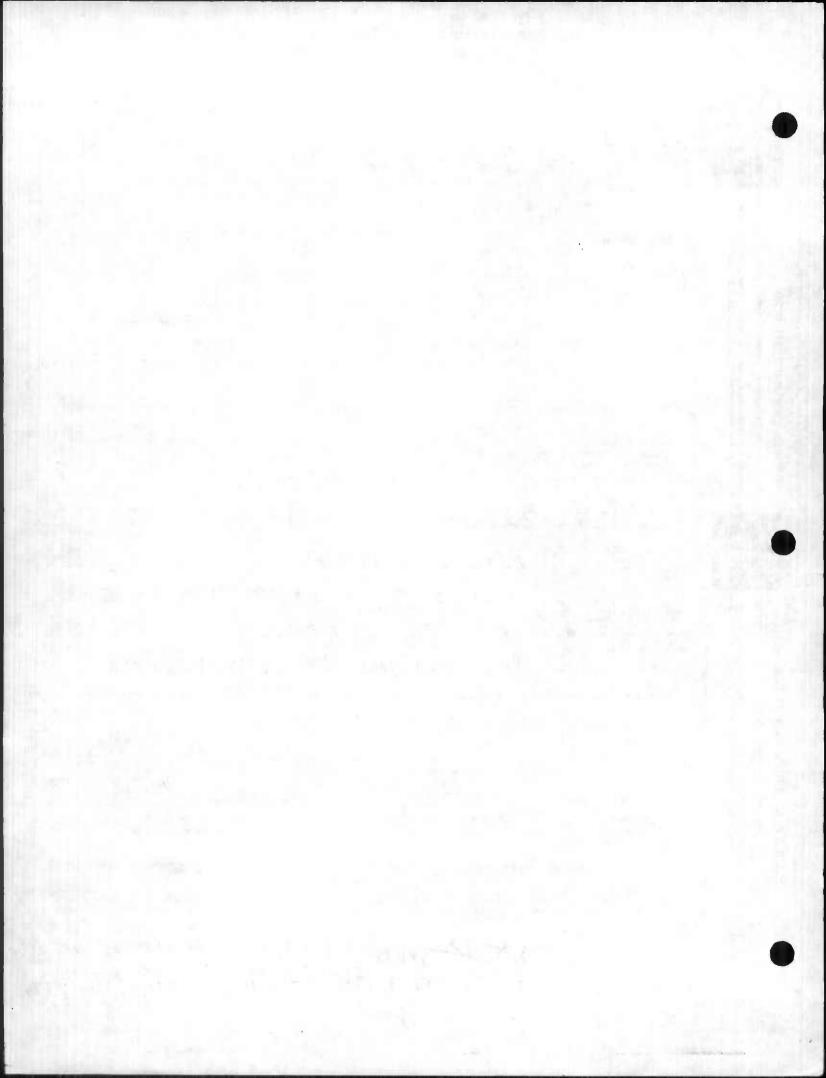
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	22. Name and Address of Fecility WILLIAM C BROWN COMMUNITY FUNERALHOME PA													
1	Charles A - 1 206 W NORTH AVENUE													
	Part1. Enter the disease, or complications that bedsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one reuse on each line.  Approximate interval Between													
	Due to (or as a consequence of):    Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   Due to (or as a consequence of):    Due to (or as a consequence of):													
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State of Maryland /	Department of Health and Mental Hygiene	-
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				Ce	rtificate of	f Death	F	leg. No.	0 1	
	ysician	1. Decedent's Name (First, Middla, L	CLARA MA	RIE T	HOMPSON		2. Date of Dea Month Novemb	th Day	Year C	2. Time of Death 2. 20 An
	ledical aminer	4a Facility Name (If not institution, g	11 11			4b. City, Town, or L		4c. County	of Death	, ,
		Jorth Arund 5. Social Security Number 6.	Sex 7. Age (In vis	s. last birthday	) If Under 1 Yea	Glen Bur if Under 24 Hrs.	8. Date of Birth	Anne		e (Stata or Foreign
Fund		212-09-3259 Usual Residence of Decedent	1□M 2\kip 87	Yrs.	Months Day	s Hours Min.	8. Date of Birth (Month, Day July 9			e (Stata or Foreign Yland
Maryland H show	¥	10a. State 10b. County	10c. C	City, Town or L	ocation				10d.	Inside City Limits
the Marylar 28s-f show	ctor		Arundel	Pasa	dena			The last		1 ☐ Yes 2 ☑ No
th kith	orner must be nounsed at Funeral Director	10e. Street and Number 257	Glen Court		10f. Zip Code	21122		USA	Vhat Country?	
2 0 after or he	P A	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	U,S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp ban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Race Blac Specify	- American k, White, etc.	
C/6 15-002 72 hours	Be Completed	15. Decedent's (Specify only highast g	Education rada completed)	16a. Dece (Givi	edent's Usual Occ a kind of work don	upation a during most of work red)	king	16b. Kind of Bu		
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- CA DOF	Be Co	17. Father's Name (First, Middla, Las	(i)			18. Mother's Nam	e (First, Middla,			е
aryland 2 should be filed of Mental Hygin		Edgar V	latts		4 100	Ruth	Hebr	ank		
M M	other treumatic	19a. Informant's Name/Relationship Richard Kelle				ny Rd.,				
Baltimore, No Maritimore, No Maritimore and Separtment of Haalth Important: If Health	ry or oth	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special	DRemoval from State	cematary, cra	osition (Nama of amatory or other p	Cem. 11	Date / 28 / 00	20c. Location - Balti		
Baltimo pemit. Paga: Department ol Important: If it	any Inju	21. Signature of Funeral Service Lic		2	22. Name and Add McCully	ress of Facility -Polynia	k Fune	ral Ho	•	
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the de	ath. Do not er	3204 Mo	untain R ying, such as cardiac	d., Pa or respiratory ar	sadena rest,	Ar	21122 oproximate tervel Between
Physic	ian	shock, or heart failure. List on	y one cause on each line.							nset and Death
/Medi Exami	_	Immediate Cause (Final disease or condition resulting in death)	PNE	Im	ONI	A				
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and and	Examiner	Sequentially list conditions	b. Ory G	(or as a conse	TVE	HEADOR	7 +0	77 [	JOKE	
50, % a.m.	the burial-transit dical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	ADR.	TTC	CTA	= MOST				
9 11 0	8 0	thet initiated events resulting in death) Last	-	or as a conse		MSCUL	AR D	ISE	PIF	
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O. # #	ached	Part II. Other significant conditions	contributing to death but not re	esulting In the	underlying cause	given in Part I.		obacco use col res 2 No		oly 4 Unknown
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nbear v redu	shoul leter						24a. Was perfo	an autopsy med?	availa	autopsy findings able prior to eletion of cause ath?
The lay	director, page 2						101	res 2 No	1 🗆 Y	res 25 No
Vital Richar The	Be C	25. Was case referred to medical examiner?				26. Plece of Dea	th (Check only o	ne)		
of V hysic	10	1 Yes 2 No	1	☐ ER/Outpatie	ent 3LI DUA		ome 5 Resid			
on of ang Phys After this	funer flon:	27. Manner of Death  1 Delta S Pending 2 Accident investigeti	28a. Date of Injury (Month, Day Year)	28b. Time Injury	W	jury at /ork? ☐ Yes 2 ☐ No	28d. Describe i	now injury occur	red	
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To the Hospital within 24 hours To the Funeral	complately filled in by the funeral Medical Certification:		Physician: To the best of my kr aminer: On the basis of examination and manner stated.							
To the To the To the	Me Me	29b. Signature and title of certifier	and mariner stated.	1919	29c. Lice	nse number		29d. Date signe	d (Month, Da	y, Year)
		· /	ma sha	m.	D	D5166	4 1	VOVEn	BER	25, 200
6	2	30. Name and address of person wh	o completed cause of death (Its VDEL HUSPI	em 23a) (Type	3 01 70	HIRK	UMAR	ASSE	ARN	PLURNIF
Re	State gistrar	NOV 2 7 2000	See 32. Registrar's Sig	gature 4	parks		1/-	n	カラ	1061

DHMH 16 Rev 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Year HOMPSON 9:37 A.M NOVEMBER 21 2000 4a Facility Name (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL CENTER BALTIMORE KOSEDALE If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex J. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 H Hours 219-01-2198 Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits BALTIMORE 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ROA 6600 212 37 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race · Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumema) WUDA LOUISA ERIVEST EL215 TUCKER HEBER 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2/207 (SON) 20b. Place of Disposition (Name of cametery, cremetory or other place) BALTIMORE MIL ROBERT THOMISON WOODGREENCIR 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State ARBUTUS MEMORIUL 11-27-00 BALLIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility HOWELL FUNERAC No ME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death)

**Physician** /Medical Examiner

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Ne Hospital or Attending P n 24 hours after death. Ne Funeral Director: After t

To the Hosp within 24 hou To the Fune completely fi

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Completed

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Certification:

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P.O. Box 68760,

Division of Vital Records,

Important: If It any Injury or o

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or itema 23a or 28a-f ahor edical Examiner must be notified at

th and Mental Hygiene.

If is marked other than "natural" fraumatic event, the Medical E.

Pages 1 and 2 should be nent of Health and Mental

HOMPSON, ANNA

Funeral Director

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Completed

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Examiner the death certificate be axecuted physician end the burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Physician/Medicai

Hypoxemin Due to (or as a consequence of): Acrest Due to (or as a consequence of): Myocardial Insperction Dua to (or as a consequence of)

23b. Did tobacco use contribute to the cause of death?

nove

hour

nor

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SAIlure

1 Yes 2 No 3 Probably 4 Unknown 24e. Was en autopsy performed?

25. Was case referred to medical

1 Inpetient 2 ER/Outpatient 3 DOA

24b. Ware autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Hospital: 1 Yes 2 No

28a. Date of Injury (Month, Dey Year) 28b. Time of Injury

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 2 Accident

5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

DRIVE, BALTIMORE, MD 21237

29e. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifiar

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

053462

11/22/00

JUDE MUNESES, MD State

31. Date filed (Month, Day, Year)

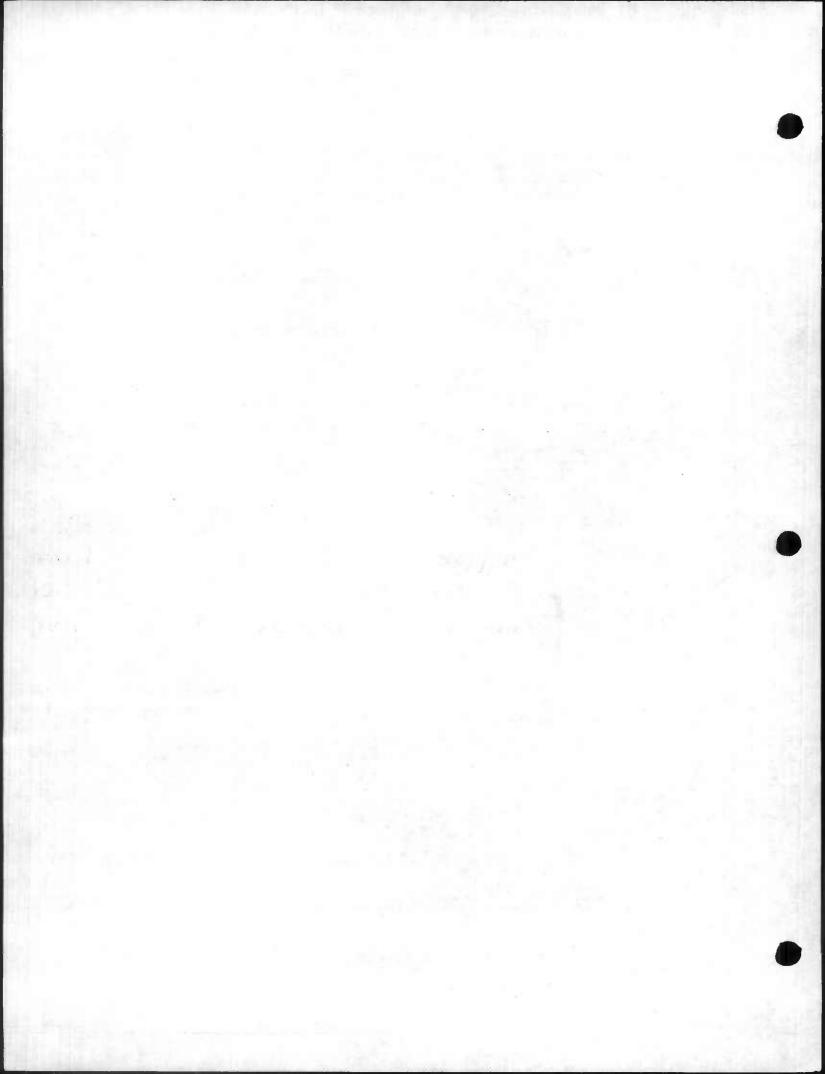
32. Registrar's Signatura

**DHMH 16 Rev 6/95** 

Registrar

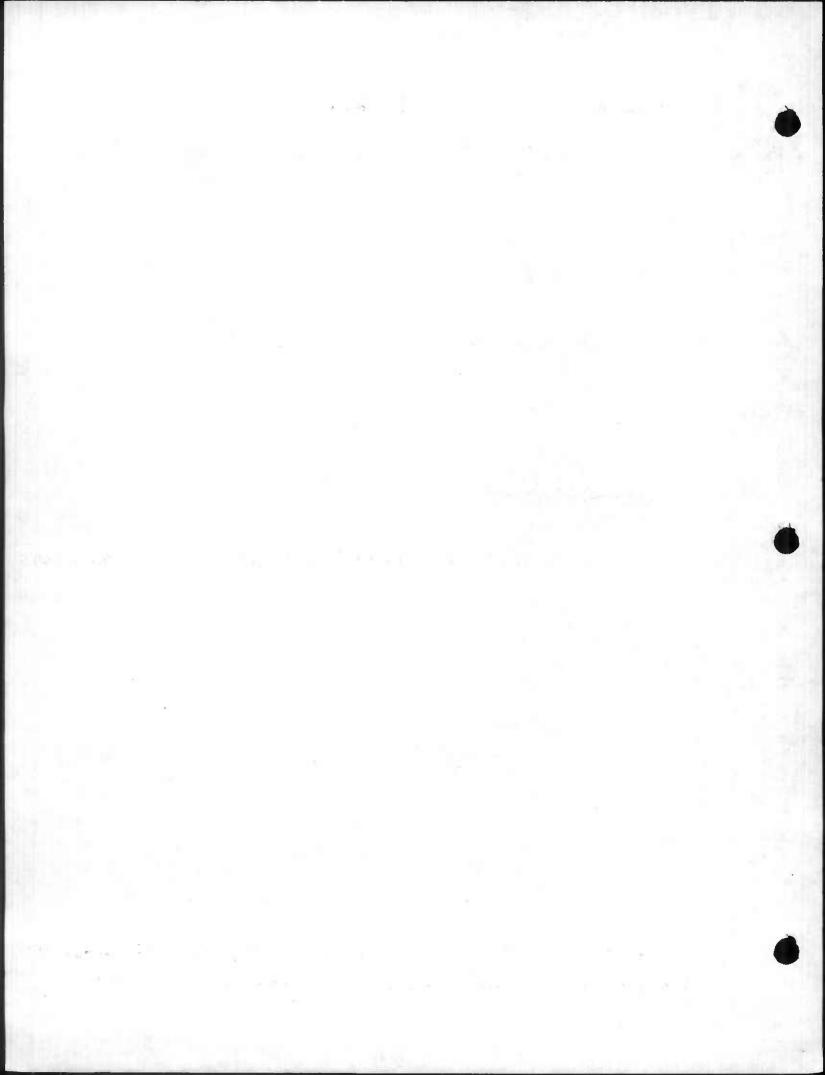
**ORIGINAL** 

9000 FRANKLIN SQUARE



item	9 per fh G789 11/27/00 yf		Certificate	e of Death	F	Reg. No.						
!	Decedent's Name (First, Middle, Last)				2. Dale of Dea		ear	3. Time of Death				
ysician Jedical	Pamela		Tuck	er	Novemb	,		23: 25				
aminer	4a Facility Nama (If not Institution, giva street and r	number)		4b. City, Town, or t		4c. County of						
	Johns Hopkins Ho	spital		Baltino	re City	N.	I/A					
al	5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months	1 Yaar If Undar 24 Hrs. Days Hours Min.	8. Dala of Birtl (Month, De)	, Yeer) 9	Birthplac	a (State or Foraig				
tor	224 04 72)4	52	Yrs.		May 18	May 18, 1948 Cauntry Pennsylvan:						
	Usuat Residence of Decedent  10a. State 10b. County	10c City To	wn or Location				104	Inside City Limits				
Director	Maryland N/A						100	1 No Yes 2 □ No				
Directo	10e. Street and Number	Dal	timore Ci			10g. Citizen of What Country?						
ä	501 Wingate Road		101. 210					•				
era		ecedant Ever In U,S.	13 Was Dacad	21210	pacifu Vac or No-	USA 14. Raca -	American	Indian				
Funeral	Armed	Forces?	If Yas, spec	lant of Hispanic Origin? (S cify Cuban, Mexican, Puert	Rican, etc.)	Bleck,	White, etc					
À	3 ☐ Widowed 4 ☐ Divorced Year or	Give	1 ☐ Yas 2	2 No Specify:		Specify:	Whi	te				
_	15. Decedent's Education		a. Decedent's Usua	al Occupation		16b. Kind of Busin	ness/Indus	stry				
Completed	(Specify only highest grada complated	d)	(Give kind of wor. life. DO NOT us	al Occupation rk done during most of wor se retired)	ing							
mo	Elementary/Secondary (0-12) College			Disease Phy		Medica	1					
Bec	17. Father's Neme (First, Middle, Last)	-		18. Mother's Nan	ne (First, Middle,	Meiden Sumeme)	me)					
OB	Weir Mitchell Tucker			Linden		Cra	wfor	đ				
-	19a. Informant's Name/Relationship (Type, Print)	15	9b. Meiling Address	(Street end Number or Ru								
	Linden Tucker Bell (Si	ister)	7/10 Oals T	I and Chart	Chase N	[a.a.a.]	2001					
	20a. Method of Disposition	20b. Place	of Disposition (Nem	Lane, Chevy the of the pleca)	Dete ,	20c. Location - Ci	2081 ty or Town	n, State				
	1 ☐ Burial 2 X Cremation 3 ☐ Removal from 4 ☐ Donafion 5 ☐ Other (Specify)	III State		rematory 1			oro	Marulan				
2 2 9	21. Signature of Funeral Service Cicenses 7	GECCI			1/2/200	O Dartill	ore,	Maryland				
	Minch 11 IV J. C. 11 D. T. IV T.											
	Martin Lawson M00358 FILCREIT-Wiedereld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212  23a. Part1. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Intervel Onset a complex of the											
	shock, or heert failure. List only one cause or	eech line.					Ir	ntervel Between Inset end Deeth				
F	Immediate Couse (Finel disease or condition resulting in death)  a. Weta state by east cancer seven year											
je l		Due to (or es	a consequenca of):				1					
Examiner	b											
Exa	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c	Dao 10 (01 a3 1	a consequence or,									
cal	trat initiated events	Due to (or as a	a consequenca of):									
Physician/Medical	rasulting in death) Last						i					
3	d											
Cla	Part II. Other significant conditions contributing to	death but not resulting	in the underlying ca	ause given in Part I.	23b. Dld t	obacco use contr	ibuts to t	he cause of death				
hys					10	Yes 2 No 3	□ Proba	bly 4 Unknow				
by P												
						an autopsy	24b. Were	e eutopsy findings able prior to				
Completed					perio	illed t	com	pletion of cause				
mo					101	res 20No	10	Yes 2 Ne				
0	25. Was case referred to medicat			26 Place of Dea	th (Check only o							
OB	exeminer? Hospital:	⊒Impatient 2□ER/0	Outpatient 3 DO	Other:		ienca 6 □Other	(Specify)					
ı.	27. Menner of Death 28a. Dat		. Time of	8c. Injury at Work?		now injury occurred		-7111				
atio	1 ☑Natural 5 ☐ Pending (MC) 2 ☐ Accident investigation	onin, Dey Year)	Injury M	1 Yes 2 No								
HC	3 Suicide 6 Could not be determined 28e. Pla	ca of Injury - At home,	farm, street, factory	/, office	28f. Location (S City or Tow	Street and Number	or Rural I	Route Number,				
Certification:	4 🖸 Homicide Duli	Iding, etc. (Specify)			City of You	m, siele)						
	29a. Certifier 1 Certifying Physician: To ti											
edical	(Check only 2 Medical Examiner: On the and ma	basis of examination a anner stated.	and/or investigation,	, in my opinion, deeth occu	rred at the time,	date and place, an	d due to ti	he cause(s)				
Σ	29b. Signatura and fitta of certifier			. License number		29d. Date signed (						
	Melande MI		R	ES-\$	001	Jovento	er ?	21,2000				
1	30. Name and address of person who completed ca		(Type Print)		y y							
1	Lucy McBride	110 Tou	er Bui	lding Johns	Hopki	ns Hosp	11					
toto	31. Date filed (Month, Dev. Year) 32.											
State istrar	31. Date filed (Month, Dey, Year) 32.	Registrar's Signature	A	1								

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey Year NOVEMBER 23,2000 **Physician** lober Eite. 8:36PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 6 Sex 8. Dete of Birth Birthplace (State or Foreign Country) **Funeral** Months Deys 1□M 2K)F Hours 215-10-6004 December 28,1915 Director Maryland Usuel Residence of Deceden 10a Stete 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Towson 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 8 21204 United States 400 Georgia Ct. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-iff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Medial Status 1 Never Merried 2 Merried 1 Yes 2 No Specify: specify: white by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondary (0-12) bank teller banking 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Elizabeth Butschky George Henry Eitel 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code, Baltimore, MD 21224 128 S. Rochester Place Sandra Lochard/cousin Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removel from Stete 11/28/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Cemetery 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc 21. Signeture of Funeral Service Licensee 6500 York Rd. 40 Baltimore, MD 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) Examiner Examine the death certificate be executed physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed is certificate has director, page 2 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 [Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Menner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Neturel 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homleide Hospital of 24 hours at Puneral D edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture end title of certifie 29d. Date signed (Month, Dey, Year) November 24, 2000 D0055 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 21204 Greater Baltimore Med Ctr. 6701 N. Charles St. Baltimore

State Registrar

**DHMH 16 Rev 6/95** 

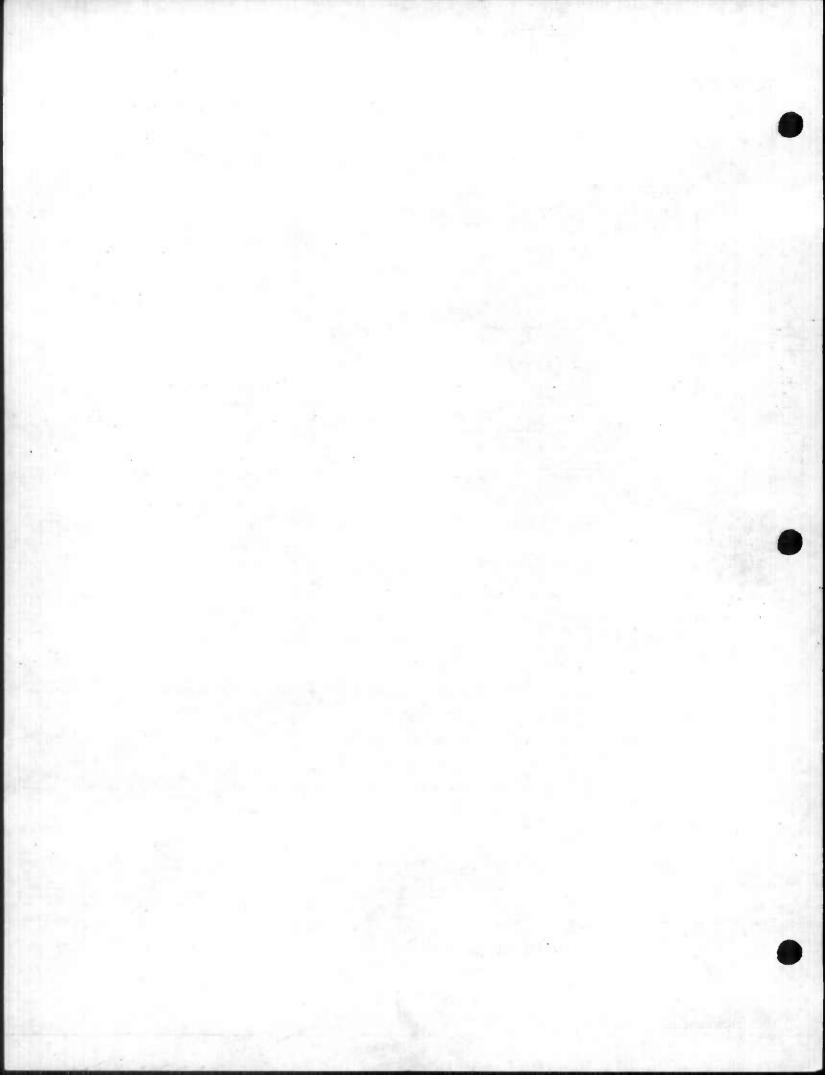
31. Dete filed (Month, Day, Year)

. M.W. lliams

32. Registrer's Signeture

M.D.

S.te 3853



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 31 per fh G789 11/27/00 yf 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Myrl P. Taylor November 25, 2000 10:00 pm /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1013 Patapsco Street Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 200 219-01-2722 82 December 19, 1917 Director MD Usual Residence of Dacedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Herns 23s or 28s-f show MD N/A Baltimore City 1 Yes 2 No Director must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1013 Patapsco Street 21230 United States Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian. iens. Than "natural", or frem the Medical Examiner. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White þ ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) De filed within Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 10 0 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Montai William Palmer Sarah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If New 27 is m any injury or other traum ance. ñ June M. Fischer / Daughter 1013 Patapsco Street, Baltimore Maryland 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial → Cremation 3 ☐ Ramoval from Stata Green Mount Crematory Nov. 30, 2000 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that seed the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on seed line. Approximate Intarval Between Onset and Daath **Physician** CAMINOMA COLON METASTAT Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequenca ot): the burial-trar Box 68760 attending physician for use as the burie Dua to (or as a consequence of)

Physician/Medical P

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FNI FN/10N

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy tindings available prior to complation of cause of death?

1 Yes 2 ₹

1 ☐ Yes Pt No

25. Was case reterred to medicat examiner? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes XX No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Distural 5 Pending 1 TYas 2 No investigation 2 Accident 6 Could not be datermined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, tarm, street, tactory, office building, atc. (Specify) 4 Homicide 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, and due to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to tha causa(s) and manner stated.

(Check only one) 29b. Signatura and title of certifie

29c. Licanse number 019640

29d. Data signed (Month, Day, Year) November 27, 2000

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

31. Date tij ed (Month, Qay, Year)

32. Registrar's

Registrar

this certificate has been signed by the ral director, page 2 should be detached

aptal or Attending Physicien: The hours after death.
Ineral Director: After this certificate by filled in by the funeral director, pa

To the Hospital of within 24 hours at To the Funeral III completely filled

Be Completed

Certification: To

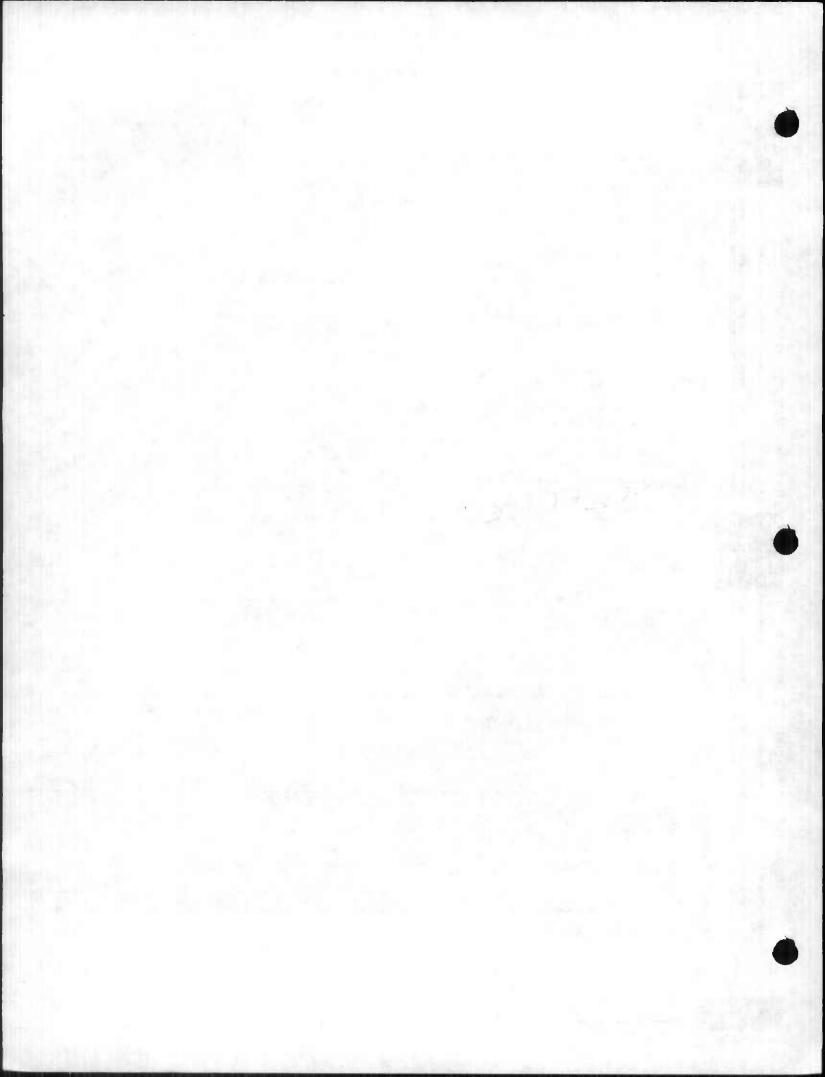
Medical

P.0.

of Vital Records.

Division

The law requires



State of Maryland / Department of Health and Mental Hygiene UU

Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle Last) 3. Time of Death **Physician** L. Thomas Donald November 21 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (ff not institution, give street and number) 4c. County of Death Examiner Baltimore St Agnes Hospital
5. Social Security Number 6. Sex 6. Sex 1 ☑ M 2 ☐ F If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Yrs. 67 11 - 17New York Director 126-26-1246 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flems 23a or 28a-f show the Wedical Examiner must be notified at WYes 2□No Director N/A Baltimore Md 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20th Street apt 17 A 21218 11 W. Funeral death 12. Was Decedent Ever in U,S.
Armed Forces?
XXIYes 2 ☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Black Baltimore, Maryland 21215-0020 1□ Yes XXNo þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Private Duty IPN 12th grade 4 years 7 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked orbh any Injury or other traumatic event poba. Be Nancy Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore Co, Md 21207 2132 Lawnwood Circle Bonnie Thomas- Daughter 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from Stete 20c. Location - City or Town, State Lansdown, Md 11-24-00 Donation 5 ☐ Other (Specify) Zion Cemetery 1. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Avenue Baltimore, Md 21215 Rone homos Han1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 105 after disease or condition resulting in death) Examiner Due to for as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Box 68760, Physician/Medical Due to (or as a consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably Wunknown 5 1 Yee 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? ortro MARIA cts Be 26. Place of Death (Check only one) Other: 4 Nursing Home 200 No Hospitel: 1 Yes 20 ER/Outpatient 3 DOA 1 Inpatient 5 ☐ Residenca 6 ☐ Other (Specify) 28c. Injury at Work? 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred edical Certification: Division 1 Accident 5 Pending Investigation Injury 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 8 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifler 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number eted cause of death (Item 23a) (Type, Print) and address of person who comp 50 25 carrine 32. Registrar's Signature NOV 2 7 2000 Registrar

The contract of the second of

#### Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Rosie Vorrath Nov. 26, 2000 8:15pm 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 3401 Sollers Point Rd. Dundalk Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Oct 26, 1909 5. Social Security Number If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) 1 M 2 K Months | Deys 212-28-1416 91 Yrs. England Usual Residence of Decedent 10d. Inside City Limits 10a Stete 10b County 10c. City. Town or Location 1 Yes 2 No Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3401 Sollers Point Rd. 21222 England 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates; Was Decedent of Hispenic Orlgin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Yrs. Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Samuel Smith Minnie Davis 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) 3401 Sollers Point Rd. Dundalk, Md. 21222 Muriel Vorrath Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 27 Bayview Crematory 2000 | Baltimore City 21. Signature of Fundrel Service Licensee 22. Name and Address of Fecility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md.21222 23e. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or hear teilure. List only one cause on each line. Approximete Interval Between Onset end Death Immediete Cause (Final diseese or condition resulting In deeth) PANCREATIC CANCER METESTATIC years Due to (or es e consequenca of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 DW 1 ☐ Yes 2 ☐ No 28. Place of Deeth (Check only one)

Physician/Medical Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be asscuted Division of Vital Records, P.O. Box 68760. signed by the a by Completed s certificate has director, page 2: Physician: Be 10 this **Juneral** Certification: After or Attending death. Director: /

**Physician** 

/Medical

Examiner

Director

Funeral

by

**Funeral** 

Director

esif, or liama 23a or Examiner must be o

'natural', or

mit. Pages 1 and 2 should be for partment of Health and Mental Hy portant: If Item 27 is marked oth y Injury or other traumatic event

**Physician** /Medical

Examine

the Medical

Baltimore, Maryland 21215-0036

25. Wes case reterred to medical exeminer? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2000 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident

6 Could not be 28t. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, term, street, tectory, offica building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner steted. 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

MD. 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY ANNE NIDIRY BALTIMORE MO 1792 BLVD MERRITT

D00052928

State Registrar

Medicai

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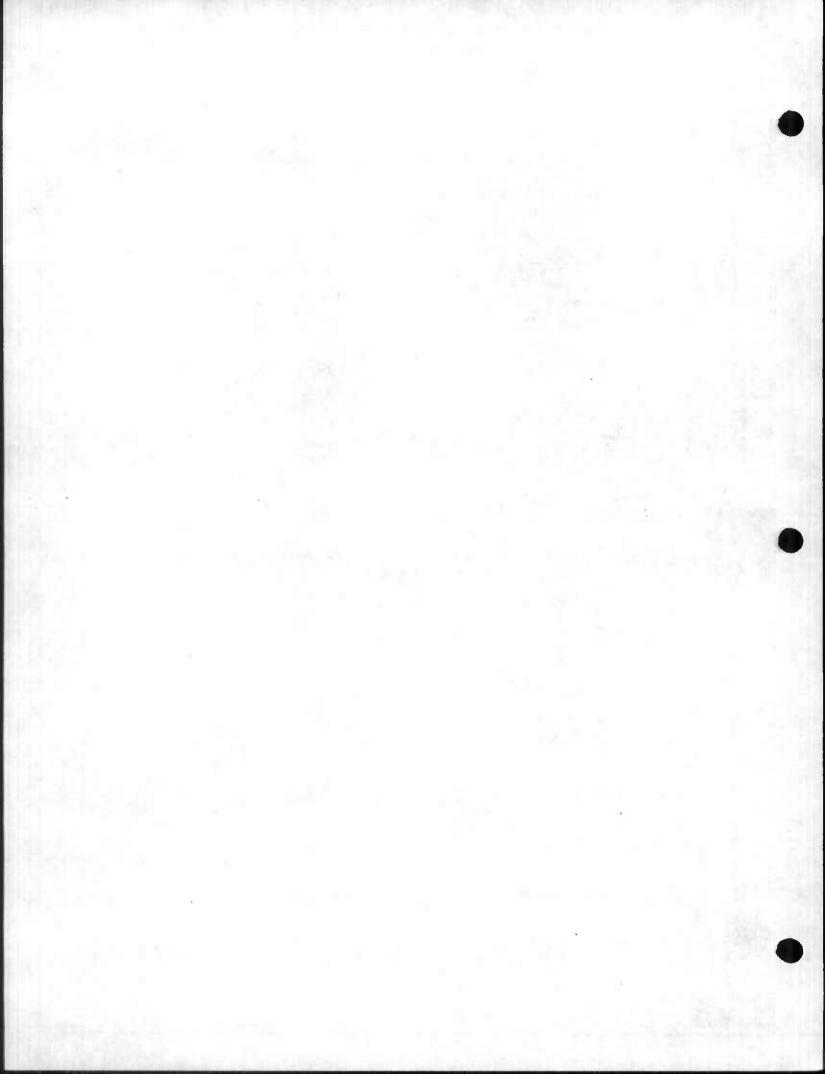
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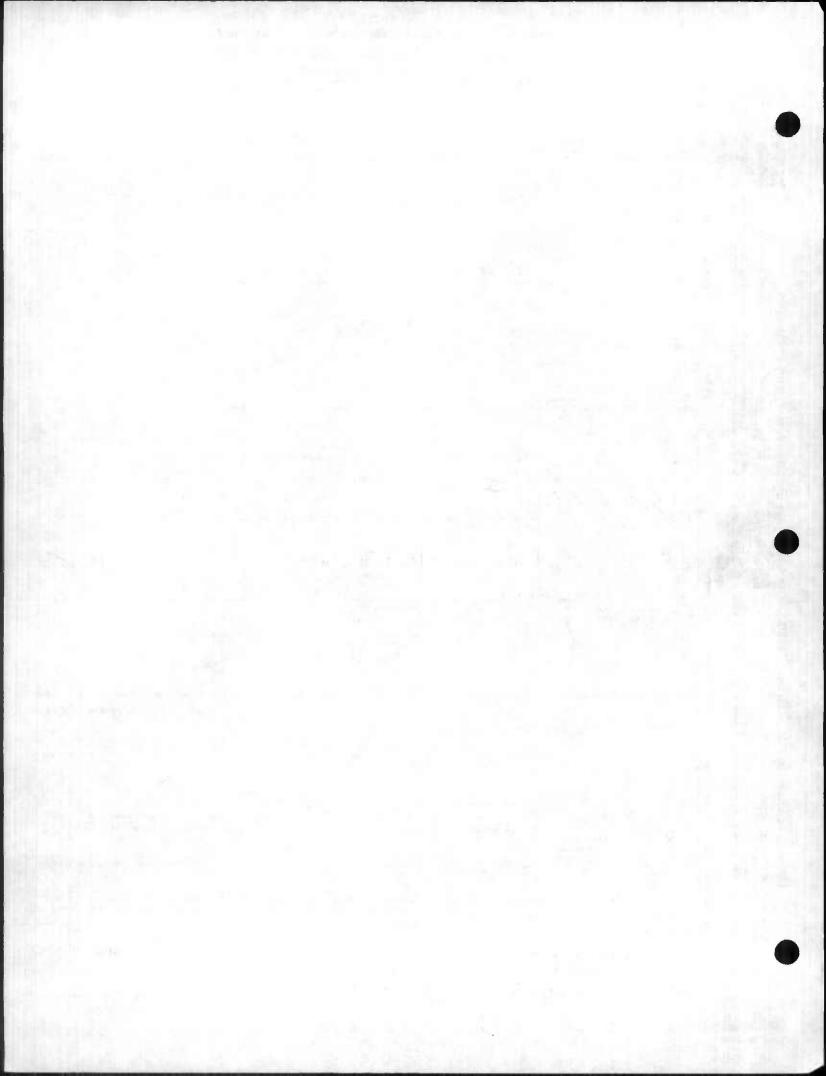
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 3 3 5

	Certificate of Death	Reg. No.			
Dhusisian	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death		
Physician /Medical	Clara Rucker Williams	November 25	2000 6:15 AM		
Examiner	4a Facility Name (If not Institution, give street and number)  4b. City, Town, or		unty of Death		
	Holly Hill Manor Baltimo		Baltimore		
Funeral Director	5. Social Security Number 216-18-7518 6. Sex 1 Months 1 M		9. Birthplace (State or Foreign Country) 23 Virginia		
nytand thow d.all	Usual Residence of Decedent  10a. Stata 10b. County 10c. City, Town or Location  Maryland N/A Baltimore		10d. Inside City Limit		
cto die o	Maryland N/A Baltimore		1 X Yes 2 □ N		
eath with the Marys is 23e or 25e-f sho must be notified at eral Director	10e. Street and Number 10f. Zip Code 21206		of What Country? ced States		
at, or then Examiner by Fun	If Yes, Give 1 ☐ Yas 21/21.No Specify: Year or Datas:	to Rican, etc.)	Raca - American Indian, Bleck, White, etc. ecify: White		
ed within 72 ho ygiene. wr then "neturn t, the Medical. Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work done	rking 16b. Kind o	of Business/Industry		
then the M	Elementary/Secondary (0-12) College (1-4or 5+)  1 agency owner	ing	ırance		
		me (First, Middle, Maiden Sur			
Martial H Martial H rhad off fic even To Be	Edwin Rucker Elsie	Cornwell Branh			
and 2 sho alth and 1 27 is me or traume	19e. Intorment's Name/Relationship (Type, Print)  Corinne Williams/daughter  19b. Meiling Address (Street and Number or Relationship Rd. 2619 Pot Spring Rd.	ural Route Number, City or To Lutherville,			
Pages 1. and of He It: If Nam y or oth	20e. Method of Disposition  1  Burial 2 M Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Greenmount Crematory		ion - City or Town, State		
Departm Importar any inju	21. Signature of Funaral Sarvice Licensee  22. Name and Address of Facility Mi  650	tchell-Wiedefe	eld Funeral Home,		
	23a. Part 1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardial schock, or heart failure. List only one cause on each line.	ltimore, MD 2	ore, MD 21212  Diretory arrest, Approximate Interval Between		
physician and specured s the burlan-transit s the burlan-transit actions adjust a state of the second secon	Immediate Cause (Final disease or condition resulting in deeth)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or as a consequence of):		Yeun		
ifficate be of physicia as the bur Nedical					
requires that the death cer been signed by the attendin should be detached for use leted by Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use	e contributa to the cause of dea No 3 Probably 4 Unknown		
requir bould hould		24a. Was an autopsy performed?	24b. Ware autopsy finding available prior to completion of cause of death?		
stelan: The law scentificate has bilinector, page 2 s		1□Yes 2	No 1 ☐ Yes 2 ☐ No		
entifica ector, p	25. Was case referred to medical 26. Place of De	ath (Check only one)			
Physician: this certific ral director, TO Be (	examiner?	Home 5 Residence 6 □	Other (Specify)		
ding Physics th.: After this tuneral	27. Manner of Death  1 Neturel 5 Pending (Month, Day Year)  28a. Dete of Injury 1 Injury 28b. Time of Vork? 2 Accident Investigation  28a. Dete of Injury 28b. Time of Vork? 3 Injury 4 Work? 1 Yes 2 No	28d. Describe how injury o			
tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicida 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	28t. Location (Street and N City or Town, State)	fumber or Rural Route Number,		
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place (Check only one)  Medical Examiner: On the basis of axemination and/or investigation, in my opinion, death occurred at the time, date end place (Check only one)	e, and due to the cause(s) an urred at the time, date and pla	d manner as stated. ace, and due to the cause(s)		
To the comple	29b. Signeture and title of certified 29c. License number		igned (Month, Day, Year) NOVEMBER 2000		
State	30. Name and address of person this completed cause of death (Item 23a) (Type, Print)  MARCILLEAUEY, MD. 1205 York Road. Sk 38. L  31. Dete tiled (Month, Day, Year)  32. Registrer's Signature	uthorville m			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 19a per informant G789 11/29/00 yf Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 22, 2000 Lewis Woodley Williams November 10:00 P.M /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1912 Arundel Road Pasadena Anne Arundel If Under 24 Hrs 9. Birthplaca (Stata or Foraign If Undar 1 Yaer 8. Data of Birth (Month, Day, Year) Aug. 10, 1931 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days 1 M 2 F Months England Hours 69 215-86-0448 Aug. Director Usual Rasidance of Decedant 10b. County 10s. Stata 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours efter deeth with the Marylan h end Mentel Hygiene. 'Ie marked other than "naturel", or fleme 23a or 28a-f ahow reumetic event, the Medical Examinar must be notified at 1 Yas 2 No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1912 Arundel Road 21122 USA Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 1 Yas 2 No if Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - American Indian, Biack, Whita, atc. 11 Maritel Stetus 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: specify: White à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Chemical Engineer Automotive Emissions permit. Peges 1 and 2 should be file Department of Heelth and Mentel Hy Important: if Item 27 is marked other any Injury or other traumatic event once. 17. Fethar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Frank Guy Williams Lilian Myrtle Woodley . Informant's Name/Relationship *(Type, Print)* Henrietta Williams <del>. 111an Williams</del> (Spouse) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1912 Arundel Road, Pasadena, MD 21122 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Nov. 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 27, 2000 Glen Burnie, MD 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licansee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) aulure Examiner hsequance of): Examine a Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaase or injury that initiated events rasulting in death) Last Dua to (or as a consagi Physician/Medical Dua to (or as a consaquanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara eutopsy findings aveilable prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yes 1 Yas 2 No 25. Was casa rafarred to medical exeminar? To Be 26. Placa of Death (Check only ona) 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 27. Mannar of Beath 1 Natural 2 Accident 28a. Data of injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 5 Pending invastigation 1 ☐ Yas 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edical (Check only one)

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To the Funeral Completely filled Hospital

the Maryland

Baltimore, Maryland 21215-0036

State Registrar

**DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year) NOV 2 7 2000

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and address of person who complated causa of daath (Itam 23e) (Type, Print)

29b. Signatura end titia of certifiar

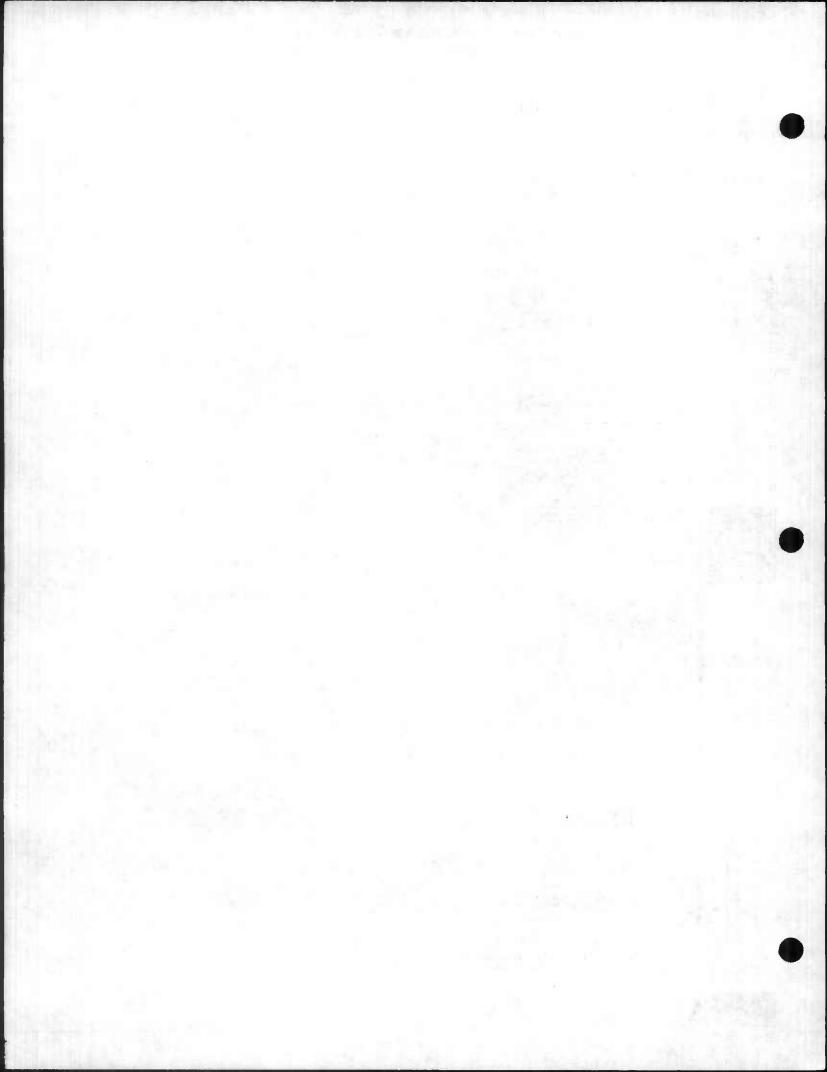
Gilbert

1450 Orleans 32. Registrer's Signature Zenen

Baltimore, Maryland 21231 CRB

29c. Licansa number Manyland

29d. Data signed (Month, Day, Year)



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Carl C. Wink November 17, 2000 10:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 117 Limestone Road Hancock Washington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1 MM 2□ F 217-12-1354 Yrs. Director February 14,1916 PA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frems 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Washington Hancock 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 'natural', or items 23a or 117 Limestone Road 21750 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or Nem any Injury or other traumatic event, the Headest Emmande. Black, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify à 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Operator Front End Loader Mining 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Albert Wink Dessie Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Step-William L. Shifflet.Sr./ 14010 Heavenly Acres Ridge Hancock MD 21750 Date 20c Location City or Town, State Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 1 N Buriat 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Thomas 'Episcopal 11/22/2000 Hancock, MD 21750 24. Signature of Funeral Service License 22. Name and Address of Facility Grove Funeral Home, P.A. 141 W.Main St. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complete shock, or heart lailure. List only of Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician /Medical Immediate Cause (Final · ADENOCARCITORA disease or condition rasulting in death) Examiner Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown For lare, Chrodic Records, Be Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical axaminar? 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Aesidenca 6 Other (Specify) 2000 Medical Certification: To 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 ENatural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26523

Registrar **DHMH 16 Rev 6/95** 

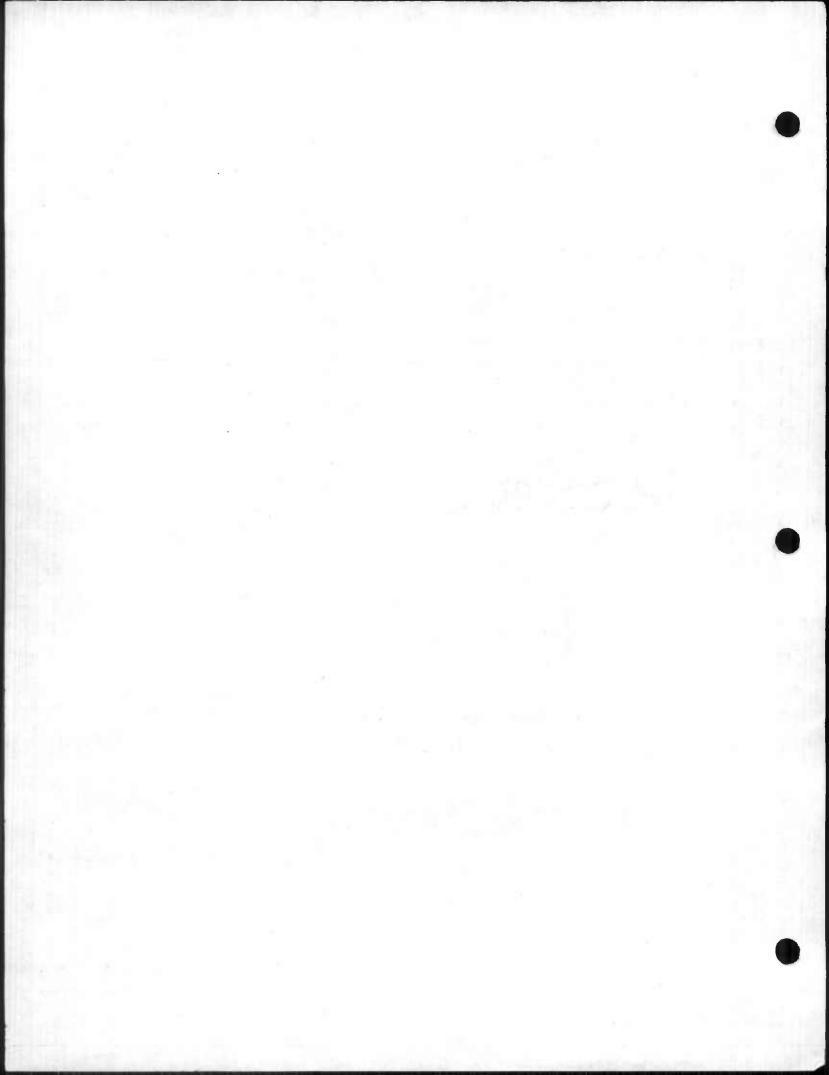
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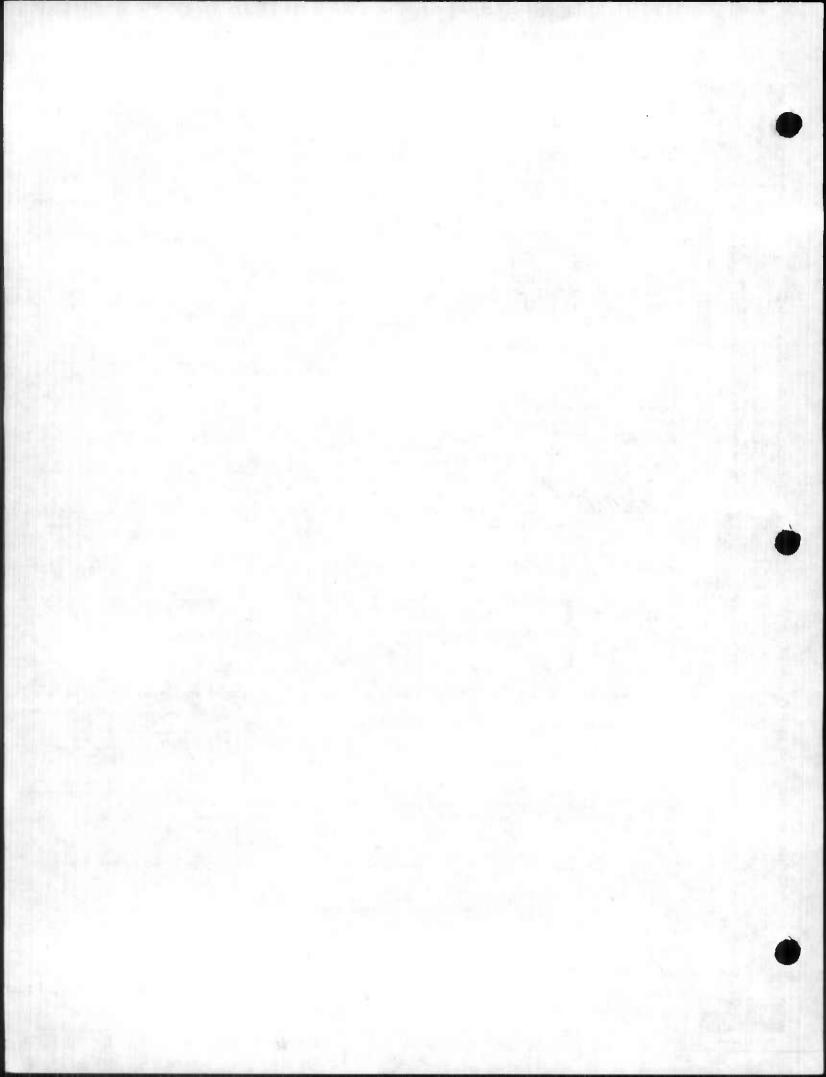
30. Name and addrass of parson who completed cause of death (Item 23a) (Type, Print)

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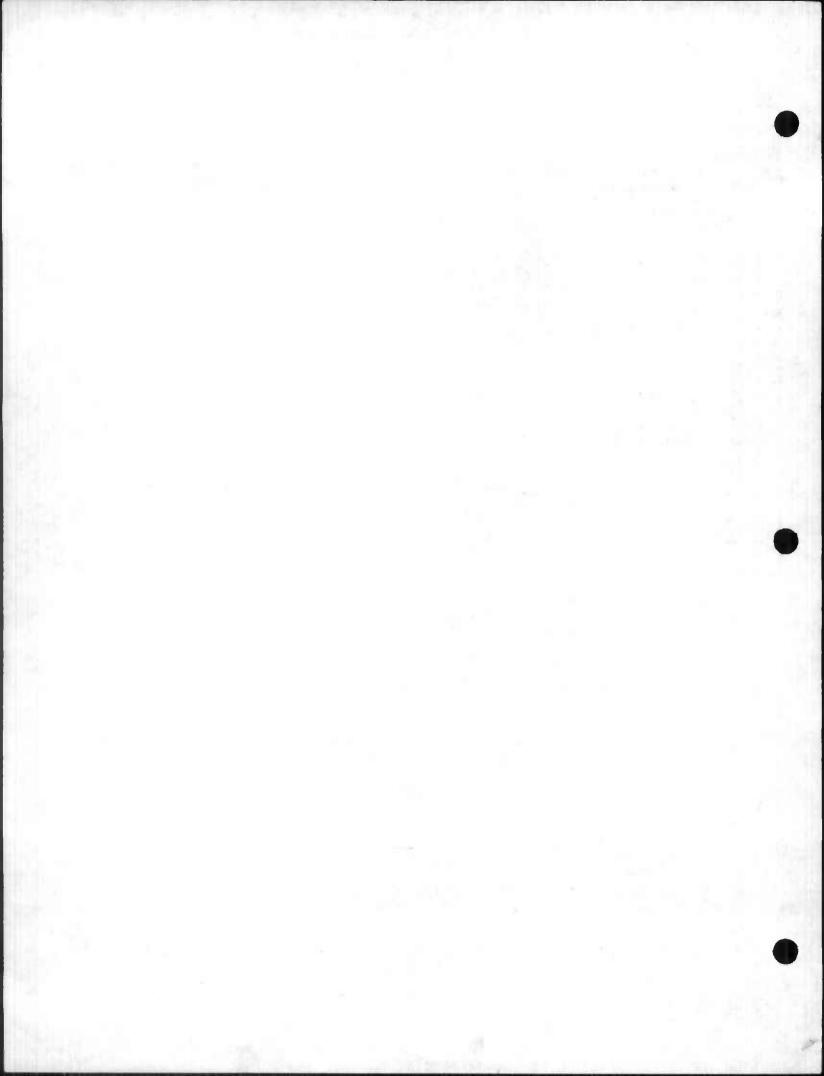
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.Physicia /Medic	_	Baby Girl	Wa	lker							NOVEME	BER 16	2000	0518	
Examin		4a Facility Name (If not instituti	on, <i>give</i> s	street end num	iber)	The state of		4	b. City, To	wn, or Lo	cation of Death	4c. County			
		UNIVERSITY OF	-		HOSPI'					'IMOF		NA			
Funeral Director		5. Social Security Number	6. Sex	M 2⊠F	7. Age (fn yrs.	last birthdaj Yrs.	Months	Days O	If Undar Hours	Min.	8. Data of Birt (Month, De)	, Year)	9. Birthpi Coun	lace (Stete or Foreign try) MD	
D 2		Usual Residence of Decedent  10a. Stete 10b. Count	у		10c. City	, Town or I	Location						10	Od. Inside City Limits	
Many Mary Media	tor	MD	NA		Ва	altim	ore							Mas 2□ No	
or 28a-f	Director	10e. Street and Number		24.137			10f. Zip	Code				10g. Citizen of What Country?			
23a sant b		2833 E. Sh:					_	2123				USA			
te do	Funeral	11. Marilai Slafus		Armed For		S. 13	If Yes, spec	lant of Hi cify Cuba	spanic Ori n, Maxican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Rad Blad	e - Americ ck, White,		
1 a a	by F	Never Married 2 Ma		1 Yes : If Yes, Give Year or Da	9		1□ Yas	2 No Specify:			Specif		ale		
z hou		15. Decede	nt's Edu	cation		16a. Dec	edent's Usua	Usual Occupation of work dona during most of working			16b. Kind of B	BIa usiness/Ind			
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d till till till till till till till til	Be	17. Father's Name (First, Middle	, Last)							(First, Middle,		na)			
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A 2 should be file th and Mental Py 7 is marked other traumatic event		19a. Informant's Name/Relation Quiana	isnip (1)	Walk	er						e Balt				
6 - F - G		20a. Method of Disposition		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20b. F	tace of Dis	position (Nen	ne of	-		Date	20c. Location			
mil. Pages 1. partment of He portant: If Item y Injury or oth	on a second	¥C≯Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		emoval from S	itate		emetory or o			רוֹר	-24-20	00 Rar	dall	stown, MD	
Sorter P		21. Signature of Funeral Service		99 /	IX.	2000	22. Name an								
g sales		WM.C.March FH 1101 E. North Avenue													
		23a. Part1. Enter the disease, shock, or heart failure. Lis	or compti	cations that ca	used the deat	n. Do not e							11100	Approximate Interval Between	
Physician /Medical Examiner		tmmediata Cause (Final disease or condition resulting in death)	8	HEAD I	NJURIES CATIONS C TIONAL DI	AS F DELI ABETES	VERY IN							Onset and Death	
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Afte fund		27. Manner of Death  1 □ Natural 5 □. Pend 2 ☑ Accident	ling tigetion		f Injury h, Dey Year)	28b. Time Injury		Bc. Injur			28d. Describe i progress				
UNISION To the Hospital or Attanding Within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical Certification:	3 ☐ Suicida 6 ☐ Coule	d not be mined	28e. Place building	of Injury - At h	ome, farm,		y, office			28f. Location (S City or Too Baltimore	Street and Num m. State) Uni	ber or Rure Versit	y Hospital,	
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thin 2 the	Med	29b. Signature and title of certif	ier -	and menn	er stated.		290	c. License	e number			29d. Dete signe	ed (Month,	Dev. Year)	
F 3 F 8		1/	1.	X.	MIP,			o.c.	M.E			NOVEMBI		7,2000	
		30. Name end eddress of perso		IPDLE		1 23a) (Typ		Penn	Stre	eet,	Baltim	ore, Man	ryland	d 21201	
Sta Registr		31. Date filed (Month, Dey, Yeal NOV 2 7 2000	r)		gistrar's Signa		ords/								

DHMH 16 Rev 6/95

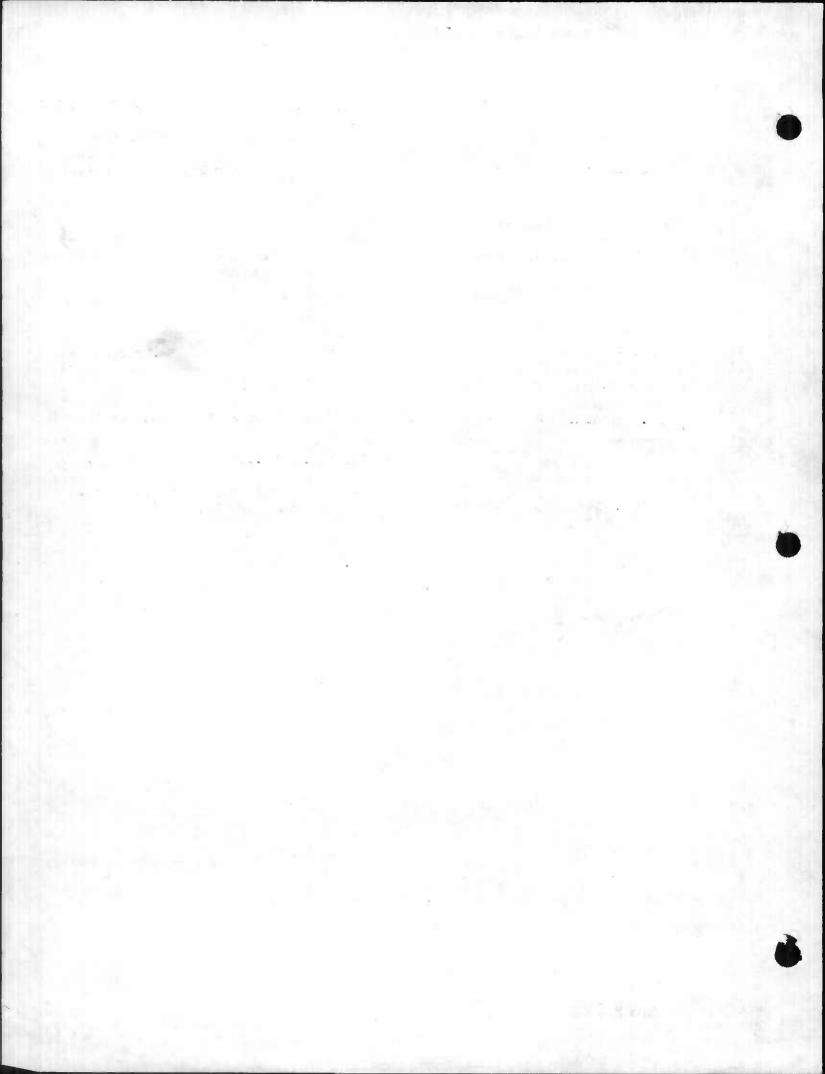


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37310

	Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death								3. Time of Death					
ician dical			Dona	ald Tho	mas	Wehner,	Sr.	Month Novem	ber 21,	Year 2000	8:15 PM			
ner		(If not institution, giv		•			4b. City, Town, o Edger	r Location of Death	4c. County Balt:					
	THE PARTY OF	5. Social Security Number 6. Se 216-72-5377		x 7. Age (In yrs. last birthdey) If		Months Days			Year) 1957	9. Birthplac Country Mary 1	Birthplace (State or Foreign Country) aryland			
Examiner must be notified at by Funeral Director	Usual Residence	1								-				
	10a. State	10b. County		10c. Cit	y, Town or L	Location				10d.	10d. Inside City Limits 1 Yes 2000			
	Maryland Baltimore Edgemere													
	10e. Street and Number 10f. Zip Code						01010		10g. Citizen of V					
			_	est Drive			21219			United States				
	11. Marital Status  1 Never Married 25 Married  3 Widowed 4 Divorced		Armed F	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cub	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 1 ☐ Yes 2⊠ No Specify:			Black, White, etc.  Specify: White				
	/50	15. Decedent's Ed	ducation		16a. Deci	edent's Usuai Occu	pation	ndeina	16b. Kind of Bu	b. Kind of Business/Industry				
	Elementery/Se	condery (0-12)		College (1-4or 5+)		re kind of work done DO NOT use retire		Orking						
	12 Years					Mechanic	+			ood Systems				
	17. Father's Nem Andrew			18. Mother's Name (Firs Mary Shel			st, Middle, Maiden Sumeme) Ldon							
		Name/Relationship ( athy A. We			211	iling Address (Stree 2 Lodge F			emere, 1	Maryla	nd 21219			
	20a. Method of Disposition  **EBurial 2 Cremation 3 Removal from State  4 Donation, 5 Other (Specify)  20b. Place of Disposition (Neme of cametery, cremetory or other piece)  Dulaney Valley Mem. Gdns 11/25/2000 Timonium, MD													
	1 H	Funeral Service Licer	0	) 0		22. Name and Addr Duda—Ruck		Ilama of	Dundall	z Inc				
	201/6	agon (	V.	lec		7922 Wice	. runeral	nome or	Maryland	7 212				
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	and the second second				h. Do not er	7922 Wise nter the mode of dy	Ave. I	oundalk lac or respiretory en	Maryland rest,	1 212: Ar Ini	2.2 oproximate terval Between nset and Death			
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DHMH 16 Rev 6/95

State Registrar



#### Please

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State of Maryland / Departme	ent of Health and	Mental Hygie	ne []	0 3	37	34	1
Certific	ate of Death	Reg	No.				
()		2. Date of Deeth	Day	Voor	3. 1	Time of D	Deat

**Physician** /Medical **Examiner** 

**Funeral** Director

with the Maryland 28a-f ahon the Madical Examiner must be notified at Herne 23e or filed within 72 hours after death ò al Hygiene. other traumatic event.

by Funeral Director

Completed

/Medical Examiner

Maryland 21215-0020 Pages 1 and 2 should be nent of Health and Mental Int: If Item 27 is marked or Baltimore, Department of Important: If It any injury or o Physician The law requires that the death certificate be executed inding physician and use as the burial-trans Box 68760, After this certificate has been Walthrop, i or Attanding P Director: To the Hospital within 24 hours a To the Funeral C

Medical Certification: To

State Registrar

**DHMH 16 Rev 6/95** 

1. Decedent's Name (First, Middle, Las November 18 2000 8: 20 PM reation of Death 4c. County of Death Y. B. Walthrop 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore
If Under 24 Hrs. 8. Date St. Agnes Hospital If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Min. Months Days Hours 1 M 2 □ F Yrs. 251-22-5015 78 9/3/22 S. Carolina Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Yes 2□No Md. Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 219 Allendale St. 21229 14. Race - American Indian. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. Vares 2□ No fives, Give Year or Dates: 43-46 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 Truck Drive Boss Linco Co. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Walthrop Evans Luella Walthrop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alhertha Walthrop Wife 219 Allendale Street, Baltimore, Md. 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest V.A.11/28/00 Owings, Mill, Md. 21. Signature of Funeral Service Lipensee Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217 23a. Pert1. Enter the discusse, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tole Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) DUC. Due to (or as a consequence of): 0 mon, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown

24a. Was an autopsy performed? 1 Yes 20 No

26. Plece of Deeth (Check only one)

24b. Were autopsy findings evaileble prior to completion of cause of death? 1 Yes 2 No

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending Investigation 6 Could not be

Hospital: 1 ☐ Inpatient 2 €F/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Enuc Baltimore 21229

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

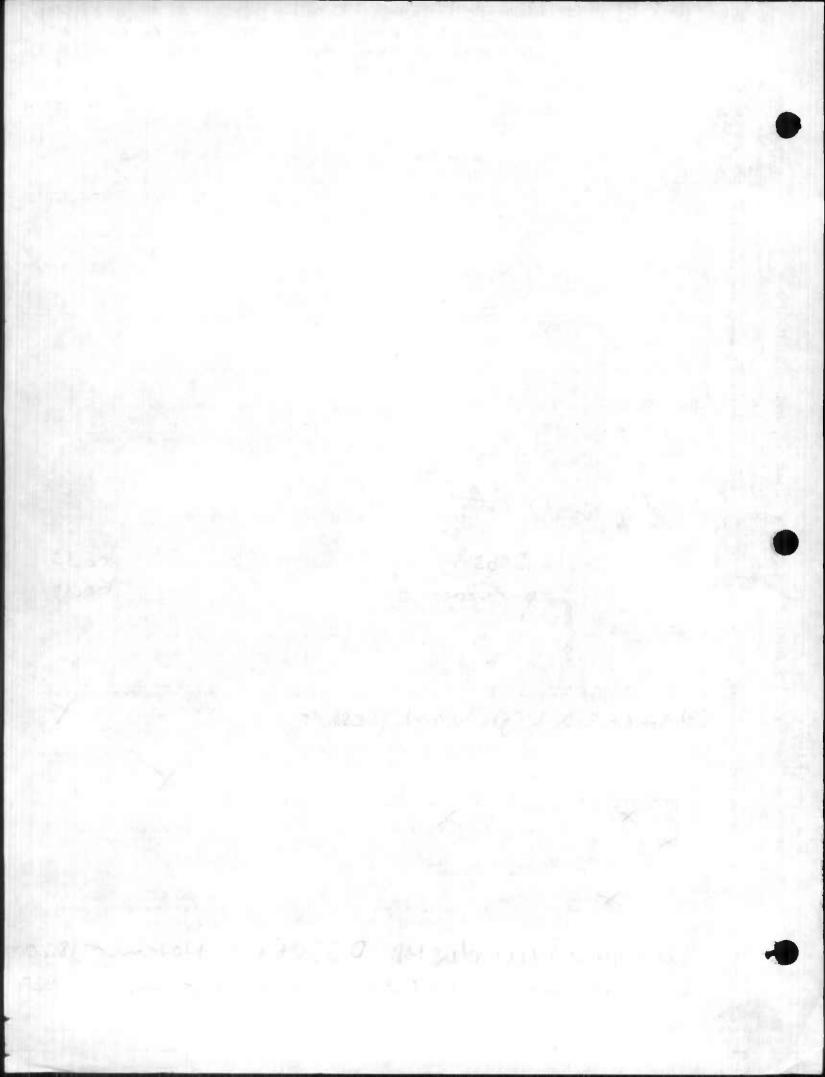
29d. Date signed (Month, Day, Year) 18,2000

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

900 ess cannine 20000

1. Date filed (Month, Day, Year)

32. Registrer's Signeture



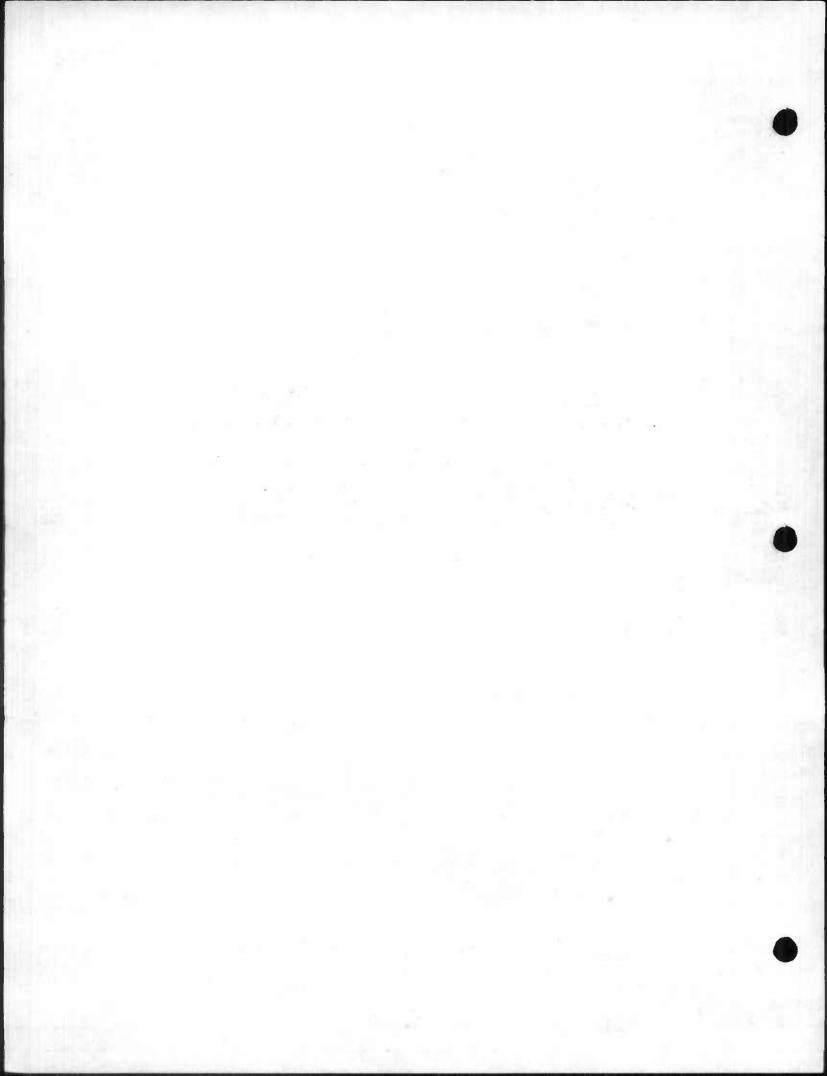
		State of Maryla		rtment of H			UU	373	48	
1.	Decedent's Neme (First, Middle, L	Reg. No.  2. Date of Death  3. Time of Death								
an cal	Dorothy E.	. Anderson				Novembe	Dey 2r 2, 2	Year 000 1:	03am	
4a	Facility Neme (If not institution, gr	ive street and number)			4b. City, Town, or Lo	ocation of Death	4c. County			
5.		Sex 7. Age (In yr.	s. last birthday)	If Under 1 Year Months Deys	Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (S Country) Orangel	itete or Foreig	
-	uel Residence of Decedent					DCC: 13	1745			
	a. Stete 10b. County  Iaryland Prince		Ft. Was						ide City Limits Yes 2 ☐ No	
	e. Street and Number		1	Og. Citizen of \						
Maryland Prince George's Ft. Washington  10e. Street and Number  4106 Maidstone Pl.  11. Merital Stetus  12. Wes Decedent Ever in U.S. Armed Forces?  1 Never Merried 2 Merried  1 Never Merried 2 Merried  1 Never Merried 2 Merried							Inited			
_	. Merital Stetus	12. Wes Decedent Ever in	U,S. 13. V	1	Hispanic Origin? (Span, Mexican, Puerto					
1 Never Merried 2 Merried Armed Forces? 1 Never Merried 2 Merried If Yes, Give Year or Detes:				Yes, specify Cub		Rican, etc.)  Bleck, White, etc.  Specify: Black				
	15. Decedent's E (Specify only highest gr	Education rade completed)	16a. Deced	ent's Usual Occup	pation during most of work	ina	16b. Kind of B	usiness/Industry	T. L.	
	Elementery/Secondary (0-12)	College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)						
17	. Fether's Name (First, Middle, Las	H)	Da	Day Care Provider			me (First, Middle, Maiden Surname)			
	Willie Young			Rosa Lee Smith				n Sumame)		
19	Pe. Informent's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street	end Number or Run		City or Town,	State, Zip Code,		
	John F. Anders	on / Husband	4106	Maidston	e Pl. Ft.	Washing	gton, M	d. 2074	4	
20	a. Method of Disposition	20b.	Place of Dispos	sition (Neme of netory or other ple	ce)	Date	20c. Location -	City or Town, St	nte	
	1 ☐ Burial 2 ☐ Cremetion 3 [ 4 ☐ Donation 5 ☐ Other (Special	Themover from Stete		Nationa		1/7/00	Triang	le, Va.		
Si if ca	sulting in death) squentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	Due to  Due to	(or as e consequence of or es e consequence or	uence of):						
Pe	nt II. Other significant conditions ASPIRATION	ven in Pert I.	23b. Did tobacco use contribute to			nuse of death				
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						1 🗆 Y	s 2 No	1 ☐ Yes	2□ No	
25	. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	e)			
P 1 Yes 200 No Hospital: 100 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other										
27. Manner of Death 28a. Date of Injury 28b. Time of Survey 28c. Injury et Work? 2 Accident investigation 28b. Time of Injury 48c. Discribe how injury occurred 1 Injury 4 Injury et Work?								red		
2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29	la. Certifier (Check only one)  1 Certifying Pi 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examir and menner steted.	nowledge, deeth nation and/or inv	occurred at the ti estigation, in my	me, date and place, opinion, deeth occurr	and due to the cred et the time, d	ause(s) and ma ate and plece,	anner as stated. and due to the c	nuse(s)	
29	b. Signature and title of certifier	n	1	29c. Licens				BER 2		
29 30 P.	(Check only 2   Medical Exa	miner: On the basis of examir and menner steted.	nation and/or inv	estigation, in my o	opinion, deeth occurr	red et the time, d	ate and plece,  9d. Date signe	and due to the c	ear)	

10 State

Registrar

DHMH 16 Rev 6/95

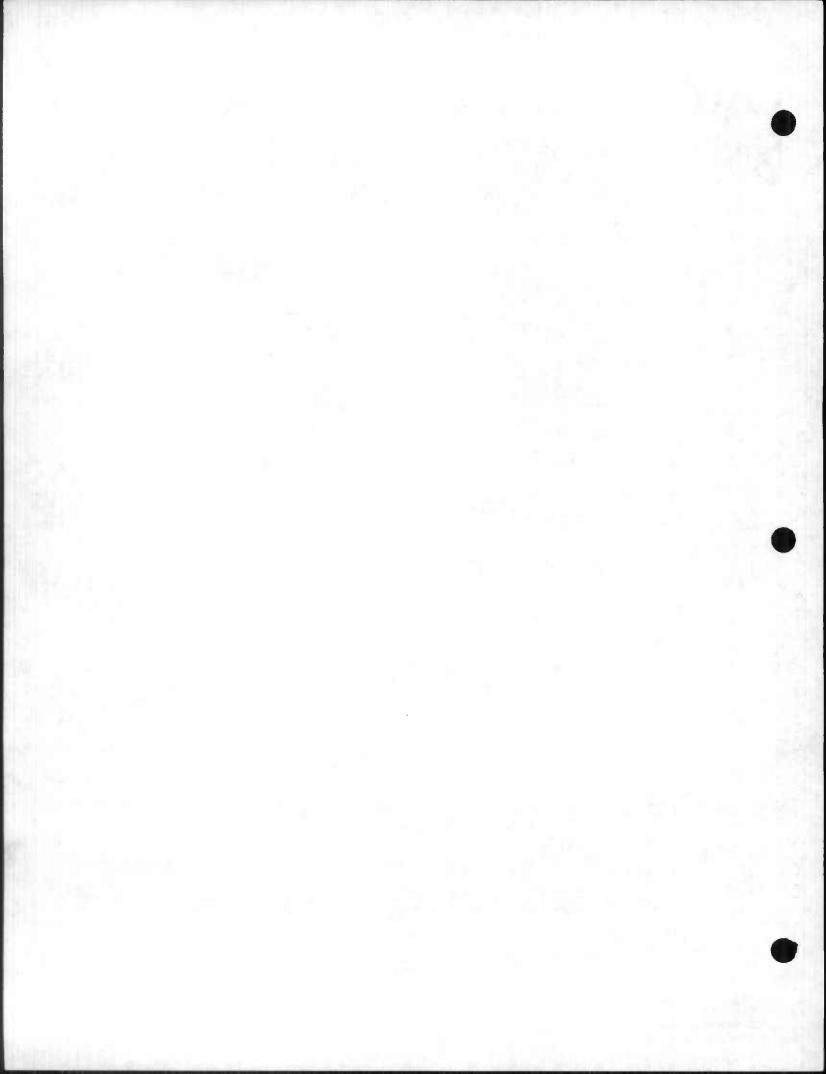
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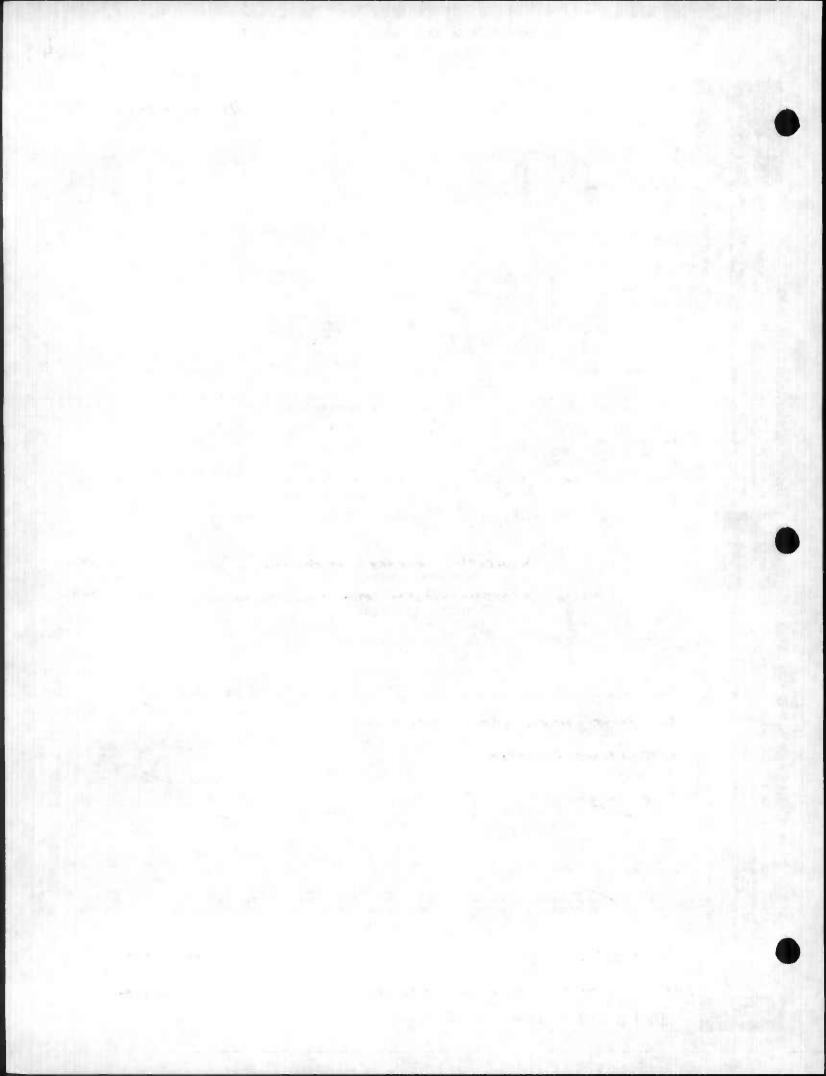
State of Maryland / Department of Health and Mental Hygiene 00 373

			Ce	rtificate of	Death		Reg. No	. 00	01040
Dhamining	1. Decedent's Neme (First, Middle, La	ist)				2. Dete of	Death Day	v Year	3. Time of Death
Physician /Medical	Edward Rollie AF		•		4b. City, Tow	n, or Location of De	7 1	County of Deeth	1448
Examiner	Washington Count					rstown		Vashingt	
Funeral	5. Social Security Number 6.	Sex 7. Age (In )	rs. last birthdey Yrs.	Months Day	r If Under 24	Hrs. 8. Dete of Min. (Month,	Birth Day, Year)	9. Birth	placa (State or Fore
Director	215-18-2045 Usual Residence of Decedent	77	- 1			June	18 19	723 Ma	ryland
death with the Menyland irra 23a or 28a-f show irrait be notified at neral Director	10a. State 10b. County	10c.	City, Town or L	ocation			-		10d. Inside City Lim
the Meryla 28e-f sho notified at	Maryland Washin	ngton	Hager	stown					1 ☑ Yes 2 ☐
vith the Me tor 28e-1 s be notified	10e. Street and Number			10f. Zip Code		- 1.7%	10g. Cit	izen of What Cou	intry?
th will	105 Sunbrook Lar	ne		2	1742			U.S.A.	
offer death v	11. Marital Status	12. Wes Decedent Ever in Armed Forces?	n U,S. 13.	Was Decedent of	Hispanic Origi	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Raca - Amer Black, White	
or he of the	1 Never Merried 2 Married	1 Yes 2 No		1 ☐ Yes 2X N		dello modii, etc.)		Consider	
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I 21215-0 led within 72 ho lygiene. Then neturing the completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usuel Occ kind of work don DO NOT use reti	upation e during most o	f working	16b. K	ind of Business/li	ndustry
within within then then then then then then then the	Elementary/Secondary (0-12)	College (1-4or 5+)							
	12	0	Corr	ectional					1 Institu
be file be file d othe event,	17. Father'a Name (First, Middle, Last					s Neme (First, Midd			
Maryland d 2 should be file th and Mental Hy 7 is marked other traumetic event	Oscar Durwood A:	A 0				e May Gu			
Mar 12 sho 12 sho 12 sho 12 sho 12 sho 12 sho 12 sho 12 sho 13 sho 14 sho 15 sho 16 sh	19a. Informant's Name/Relationship			•		or Rural Route Nur			
C = 21 F	Nora Arnsparger 20e. Method of Disposition			Sunbroo osition (Name of	k Lane	Hagerst	7	Mary Land ocation - City or 1	
0 8057	1 🕅 Burial 2 □ Cremation 3 [		cemetery, cre	matory or other p	(ace)		100		
timent thent: I tent: I	4 Donation 5 Other (Special			ven Ceme		11/15/00			Marylan
Baltimore, permit. Peges 1 e popertiment of Hee important: If flem any injury or othe pace.	21. Signature of Funeral Service Lice	and and	2	2. Name and Add				eral Hom	
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	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.	eath. Do not er	iter the mode of d	ying, such as c	ardiac or respiratory	y errest,		Approximate Intervel Between
Physician		0.0		1 0	A .				Onset and Death
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	· IVILLO	Cardie	1 d	Havel	un		1	2-1 Ho
5		Duet	o (or es e conse	equence of):	V,	2 N.	!		1- 11-10
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and al-tre	Sequentially list conditions, if any, leading to immediate	Due to	o (or as a conse	quenca of):		U,			1 11.00
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		d							
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P.O. BO) het the deeth ce ed by the attend deteched for us							□ Yee 2		11
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cord require been si should leted						24a. W	es en euto	psy 24b. V	Vere autopsy findin
DI 23 DI						-			completion of cause of death?
The law tee has pege 2	SECOND STATE					1	☐ Yes 2	No 1	☐ Yes 2☐ No
Vital Representation of the land of the la	25. Was case referred to medical examiner?				26. Plece	of Deeth (Check on	ly one)		
Of V Physics this ce tal direct	1 Yes 2 No	Hospital: 1 ☐ Inpatient	ER/Outpatie	nt 3 DOA	Other: 4 Nurs	ing Home 5 R	esidenca	6 □Other (Spec	city)
ding Phy. After thi funeral funeral	27. Menner of Death 1 Netural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time	of 28c. In	jury at ork?	28d. Descrit	be how inju	ry occurred	
SiO Seeth. For: At the fu	2 Accident investigation	n			□Yes 2□N	0			
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C Seption of									
tosp 4 hou une ety fi	(Check only 2 Medical Example 1997)	nysician: To the best of my inner: On the basis of exam	knowledge, dea	th occurred at the	time, date and	placa, and due to to	he cause(s	) end manner as d place, and due	stated. to the ceuse(s)
Division C To the Hoppini or Attending Pl within 24 hours elter death. To the Funear Director: After the completely first in by the funera Medical Certification:	one)	and manner stated.							
OT STORY N	29b. Signature and title of certifier			29c. Lice	nse number	11		te signed (Monti	
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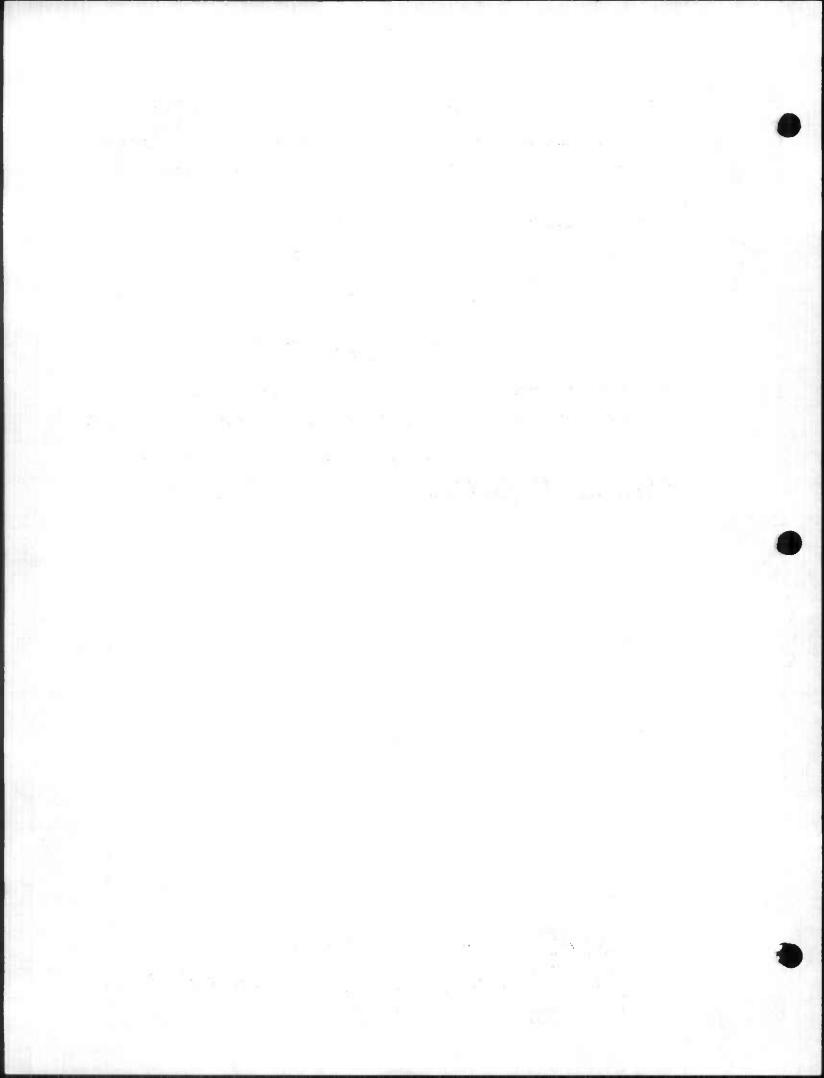
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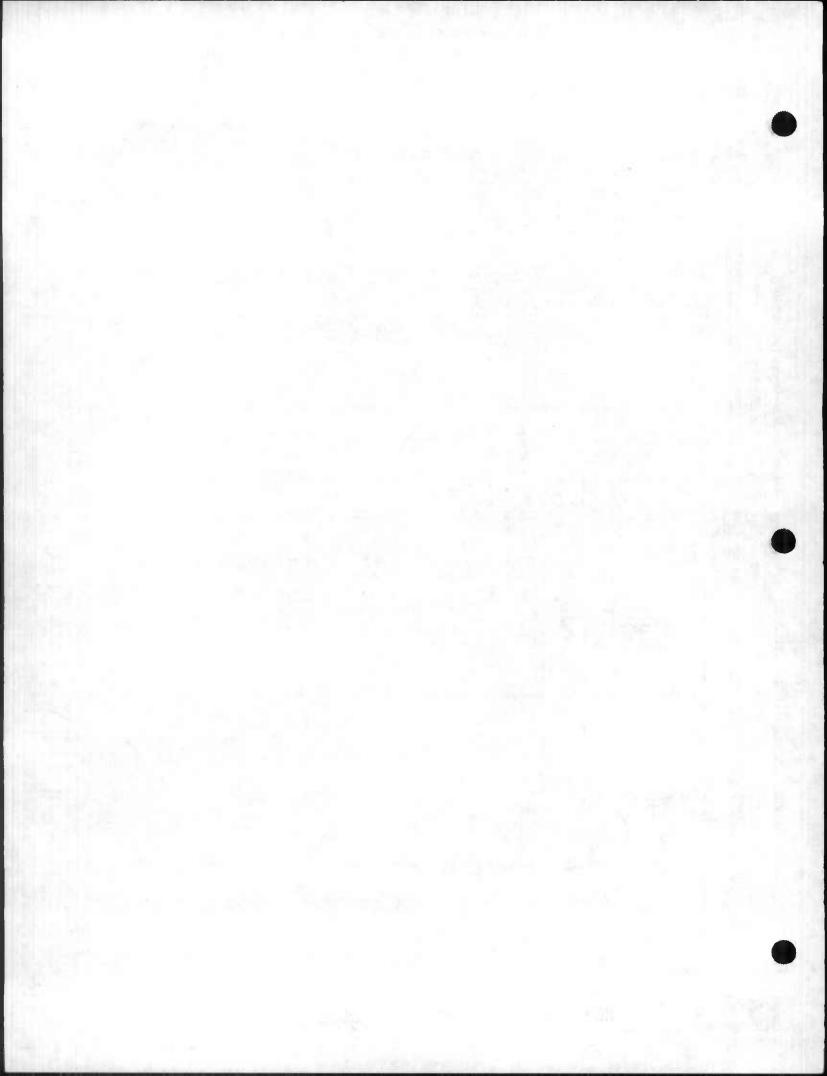
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State of Maryland / Department of Health and Mental Hygiene 0 0 37346

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-	-		5. Social Security Number 6. Sex		last birthday	If Under	1 Year	If Under 24 I					or Foreign
	Funeral Director			M 2□F 7		Months	Days	Hours N	Sept.	10, 1922	Nebr	ace (State of ry) aska	
	D		10a. State 10b. County	10c. Ci	ty, Town or L	ocation					10	d. inside C	City Limits
	Sa-f sho	Director	Maryland Freder	ick		New M		t					2 No
	er death with the Marytar Harra 23a or 28a-f show the mast be notified at		10e. Street and Number 5740 Green Valle	ey Rd.		10f. Zip	Code 217	74		10g. Citizen of W		ry?	
020	hours after dea turaf, or flams at Examinar m	by Funeral	11. Merital Stetus  1 ☑ Never Merried 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U Armed Forces? 1∑ Yes 2 ☐ No If Yes, Give Year or Dates: 1941-		Was Deced If Yes, spec		ispenic Origin? in, Mexicen, Pu Specify:	? (Specify Yes or luerto Rican, etc.)	No- 14. Race Blec Specify	- America k, White, e		
9	72 ho natur fical	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usua	I Occup	ation	unding	16b. Kind of Bu	siness/Indi	ustry	
Maryland 21215-0020	within 7 ens. the Med	Comple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life	DOMOT	a cotions	during most of prinalist aging e		automot	ive c wspap		
0	Hyg Brand	0	17. Father's Name (First, Middle, Last)	A ELECTION	1-0-0					lle, Maiden Sumam	e)		
an	d be a	o Be	Fred Irwin Archibal	d			200	Edna	Esther	Olson			
7	d Mou	-	19a. Informant's Name/Relationship (Ty)		19b. Meil	ing Address	(Street			nber, City or Town,	State. Zip (	Code)	
	and 2 seath ar n 27 is ser tress		Richard R. Burgee/	per. rep.	30 W	. Pat	rick		Frederic	ck, MD 21	701		
timore	Pages 1 tent of H int: If the iny or off		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emovel from State	Place of Disp cem <i>etery, cre</i> rroll	matory or o	ther plac		11/8/00	20c. Location - Hampst			
Balt	permit. Departm Imports any inju		21. Signature of Funeral Service License	O. Xlandle				ss of Facility I		Funeral		762	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused in e dee								Approxima Interval Be	etween
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (	-01-	0 +		par	vm o.	117		Onset and	Death
		ě	Tooling it down,					Ton	51101-	- C A	1	3,	(7/2)
	and I-transit	Examiner	Sequentially list conditions, if any leading to immediate		or as a conse		10	2011	7. (0)				
68760,	icate be executed physician and s the burial-transit	edical E	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		or es e conse			C7			- 1	13/	70
	that the death certificate be exe ned by the ettending physician a edetached for use as the burial-	2	resulting in death) Last	I		,							
Вох	death de etten	Physician/											
	the de	ysic	Part II. Other significant conditions con	tributing to death but not res	sulting In the	underlying o	ause giv	en in Part i.		id tobacco usa cor		1	
S, P.O.	s that the need by a detact								1	Yes 2 No	3 Prob	ably 4	Unknown
Records,	law requires thet as been signed to 2 should be det	Completed by							24a. W	es en eutopsy nformed?	con	ere autopsy ailable prior apletion of death?	rto
R	0 - 0	E							11	Yes 20 No	10	Yes 2	7 No
a	ician: The certificate rector, pag		25. Was case reterred to medical					00 Di				7100 20	
Vital		o Be	examiner?	lospitel:	1500		Oth	ar.	Deeth (Check on		(0)4	.)	
n of	£ = 5	on: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of injury	of 2	Bc. Injur Wor	y at k?	-	esidence 6 Oth		,	
Division of	i or Attending Patter death. Director: After i	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Ath building, etc. (Special	nome, farm, si	M treet, factor		Yes 2 □ No		n (Street and Numb Town, State)	er or Rural	l Route Nur	m <i>ber</i> ,
_	Hospita 24 hours Funeral stely fille	edical Ce		sician: To the best of my knorer: On the basis of examine and manner stated.									(s)
	within 2 To the	M	29b. Signature and title of certifier			29	. Licens	e number		29d. Date signer	d (Month, I	Day, Year)	
	₩ ¥ ¥ ₩ 8		12	7/									
							119	2 26		Nou	8	200	0
			30. Nama and address of person who co	mpleted cause of death (Ite	m 23a) (Type	, Print)	u	5	79 (5	Nov		21701	1 04
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist/ar's Sign		4	1						
	Registr	ar	NUV 137	11111	1	7	1000	1-1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** 11,2000 ASHLIN SR. 0120 NOVEMBER /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BERLIN If Undar 24 Hrs. ATLANTIC GENERAL HOSPITAL WORCESTER If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Data of Birth (Month, Day, Year) **Funeral** Months Days Hours MM 2DF 000 Director 021-22-9518 7-14-29 MASS Usual Rasidance of Deceda 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No DEL. SUSSEX SELBYVILLE Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19975 30 A SWANN DRIVE Funeral 12. Was Decedent Evar in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status 1 ∑Yes 2 No If Yas, Give Yaar or Datas: 1 Never Married 2 Married 21215-0020 1 Yas 2 No Specify: WHITE 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working tifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) 12 MANAGER SANITARY COMMISSION Maryland 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) 1 and 2 should be it leath and Mental H im 27 is marked off OSCAR ASHLIN EDITH MAE LAFOGG 19a. Informant's Neme/Relationship (Type Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) of Health I SPOUSE 30A SWANN DR., SELBYVILLE, DEL., 19975
20b. Place of Disposition (Nama of Data 20c. Location - City or Town, Stata MARGARET S. ASHLIN Baltimore, 20a. Mathod of Disposition Place of Disposition (Nama of cematary, cramatory or other place) Pages 1⊠Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 11-14 BRENTWOOD, MD FORT 21. Signature & Fundal Se 22. Nama and Addrass of Facility ULLRICH FUNERAL HOME BERLIN Approximata interval Between Onsat and Death 23a. Puls. Enfer the disease, or complications that caused the death. Do not enter tha moda of dying, such as cerdiac or respiratory arrast, or heart failure. List only one ceuse on each line. **Physiclan** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Physician/Medical Examiner Sequantially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Diseese or injury that initiated avents rasulting in death) Last The law requires that the death certificate be execu Box 68760. Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of gleath? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I P.O. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Be Completed by 24b. Wara autopsy findings 24a. Was an autopsy performed? available prior to complation of causa of death? this certificate has 1 Yas 2 No 1 Yas 2 No or Attending Physician: 25. Was casa ratarrad to medicel axeminer? 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 DNatural 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred after death.

Director: After ti
d in by the funare Division 5 Panding 1 Yas investigation 2 No 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Steta) 28a. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifian and manner stated

Registrar

31. Date filed (Month, Day, Year) 4 2000 32. Registrar's Signature

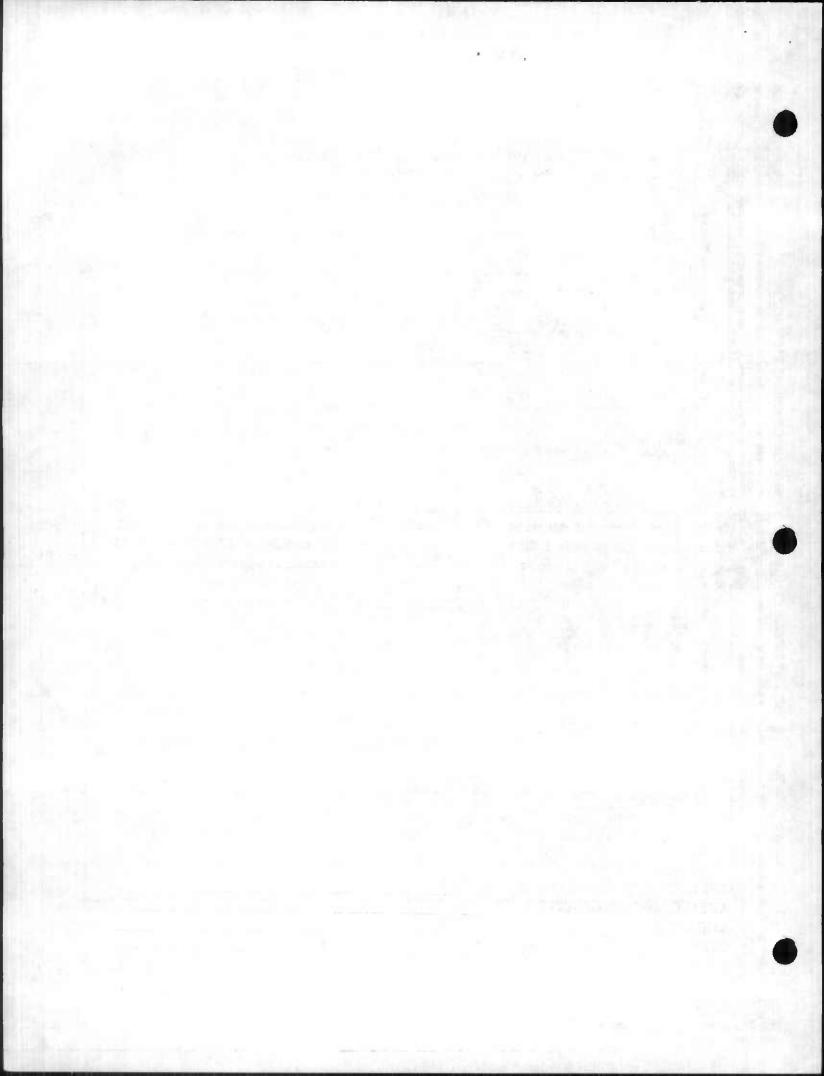
30. Name and address of person who completed ceuse of death (Itam 23a) (Type, Print)

29c. Licansa number

29d. Pata signed (Month, Day, Year)

DHMH 16 Rev 6/95

Roy



		Pleas	e Type or Pri State of M	aryland / D	Indelibie Ir epartment o Certificate o	f Health and	-	0.4	0	7348
		1. Decedent's Neme (First, Middle,	Last)				2. Dete of De Month		Yeer	3. Time of Death
	Physician /Medical	ALFRED		AL	JGUST	ALBERT		Dey 9	2000	6PM
	Examiner	4e Facility Name (II not institution,	give street and number)			4b. City, Town,	or Location of Deal			
18		12139 Sinepuxer	nt Rd.		Contract L	Berlin		Wor	ceste	r
D	uneral irector	5. Social Security Number  015-30-7962  Usuel Residence of Decedent	1⊠M 2□ F	ge (In yrs. last birth	Months Da		in. (Month, D	27,1940	9. Birthpl Count Con	ace (State or Foreign lry) necticut
Maryland	Med at	DE 10b. County Kent		10c. City, Town Dove					10	0d. fnside City Limits 1 1 Yes 2 □ No
h with the	at be notified at Director	10e. Street and Number 760 Holly Drive	9		10f. Zip Coo			10g. Citizen of V	Vhet Count	try?
1215-0020 within 72 hours efter death with the Maryland	at, or items 23s or 28s-f show transper must be notified at by Funeral Director		Wac Chio	?		of Hispenic Origin? Cuben, Mexican, Pu No Specify:	(Specify Yes or N lerto Rican, etc.)		e - America ck, White, e v: Whit	etc.
21215-0020 d within 72 hours of	natural ledges	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	Decedent's Usual Od Give kind of work do life. DO NOT use re	one during most of a stired)	working	16b. Kind of Bu		
CA DE	Ser O	6		Но	rse Trair					ning Farm
Maryiand	1 5 m	17. Father's Name (First, Middle, Li					Files	e, Meiden Sumen	10)	
Baltimore, Mar permit. Pages 1 and 2 sh	them 27 other tr	Linda L. Woolfo  20a. Method of Disposition  1	Removel from State	20b. Placa of l	B9 Sinepu: Disposition (Neme of a cremetory or other Henlopen  22. Name end Ac The Bur	Cremator	y ii-i0-0	20c. Location -	City or To	
		23a. Pert1. Enter the disease, or c shock, or heart tallure. List o	omplications that cause nly one cause on each l	d the deeth. Do no	108 Willia	m St., B	erlin, Me	d. 21811		Approximate Interval Between Onset and Death
/ /N	/sician ledical aminer	Immediete Cause (Final disease or condition resulting in death)	· metast	Due to (or es a co	Lianant onsequenca of):	melan	ma		1	18 months.
68760, ifficate be asscuted	physician and is the burial-transit edical Examiner	Cause. Eitter Oricerrying	b	Due to (or as e co						
×		rosuming in occasin, cast	<b>d</b>			- 2				
O. at	d by the latached		s contributing to death t	but not resulting In	the underlying cause	e given in Pert I.		tobacco uss co		the causs of death?
of Vital Records, Physician: The law requires that	2 should					171	24a. We	s en eutopsy formed?	ave co	ere eutopsy findings eileble prior to mpletion of cause death?
E &	pege Com						10	Yes X No	10	Yes 2X No
/Ita	ector.	25. Was case referred to medical examiner?	Market			4 7 7	Death (Check only	one)	Home	e of friend
of Vita Physician:	H G	1  Yes <b>%</b> No	,	ient 2 ER/Oul			g Home 5 Res		ner (Specif)	or mena
E 5	After	27. Manner of Death  1 Netural 5 Pending 2 Accident investige 3 Suicide 6 Could no	t he	e <i>y Year)</i> In	М	Injury at Work? 1 Yes 2 No		how injury occur		
5 b	al Director: led in by the Certifica	3 Suicide 6 Could no 4 Homicide determin	ad Zoe. Pleca of in	njury - At home, fan itc. (Specify)	m, street, factory, of	fica	28f. Location City or To	(Street end Numi own, Stete)	per or Rure	r Houte Number,
The Hospital	To the Funeral Completely filled	29e. Certifier 1 Certifying (Check only 2 Medical E.	Physician: To the best caminer: On the basis of and manner s	of examinetion and						
To the	To the	29b. Signeture end title of sertiller	20	)		cense number	07091	29d. Date signe	d (Month,	Dey, Year)

30. Nitime and address of person who completed cause of deeth (Item 23e) (Type, Print)

SANDRAC. FOOTE ND BAYHEALTH MEDICAL CTR MILPORD, DE 19963

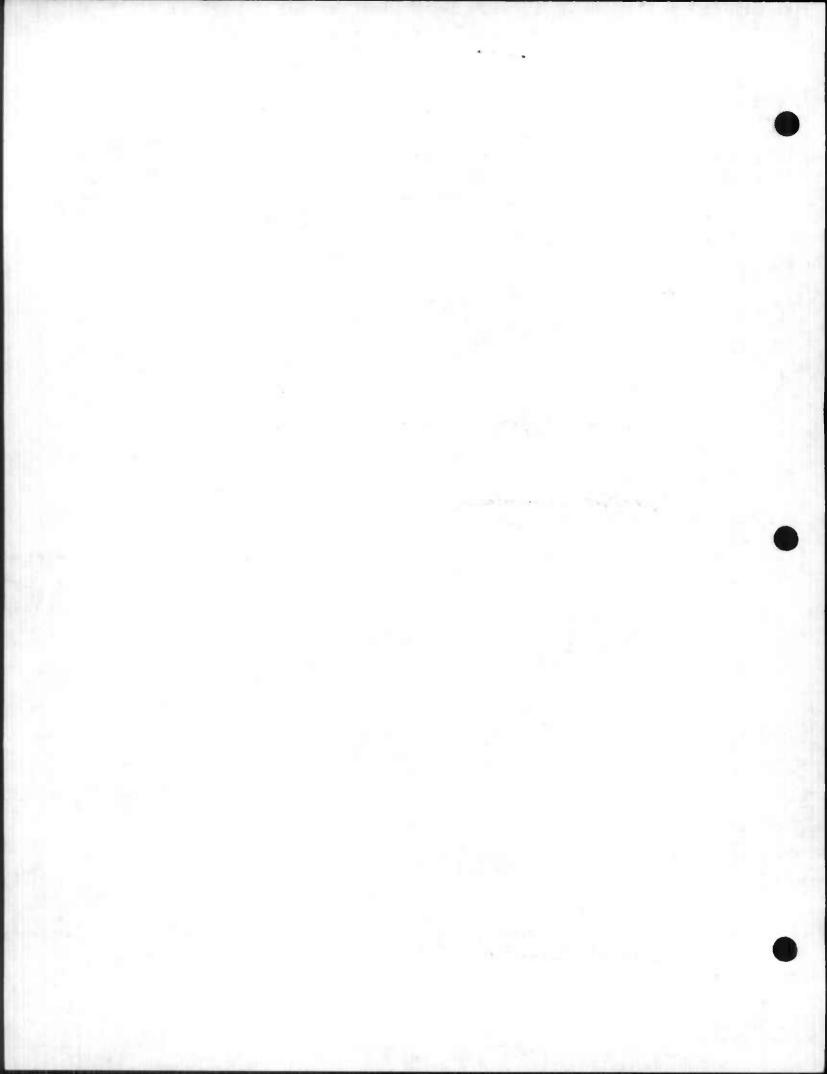
31. Date filed (Month, Day, Year)

NOV 1 3 2000

32. Registrar's Signature

4. Aparlla

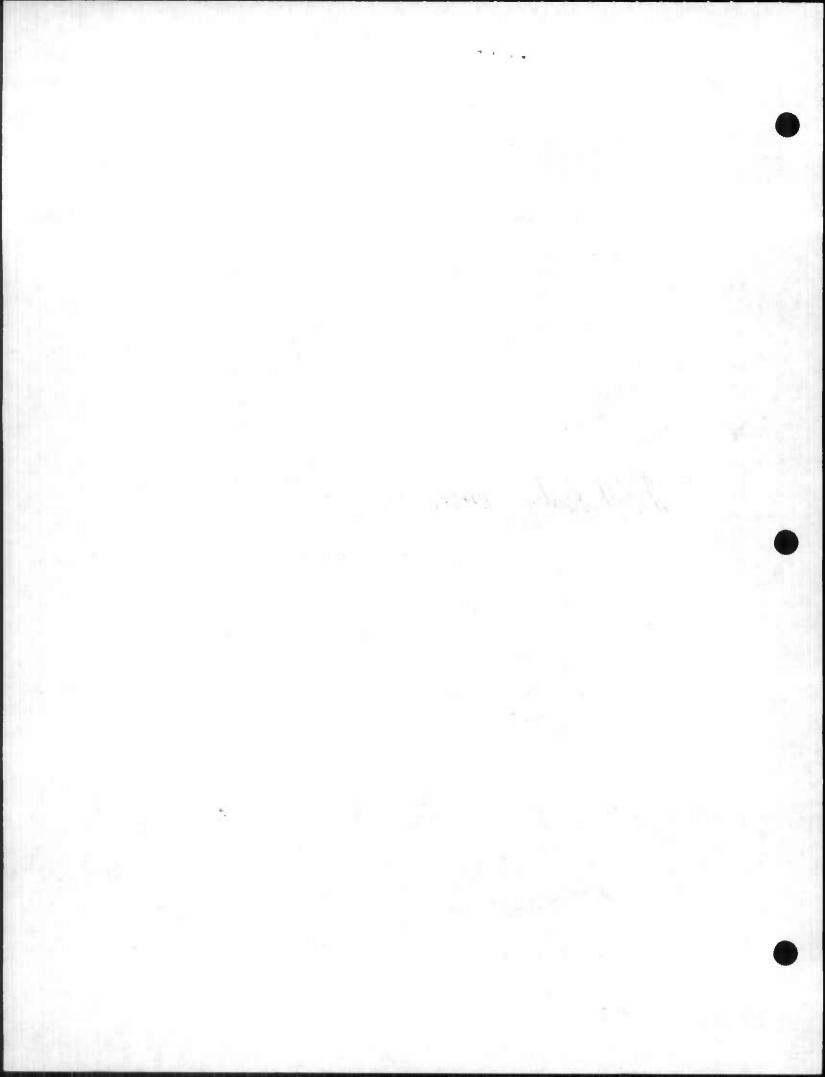
State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 37349 Certificate of Death

	cedent's Name									Month	Day	Year	
ician dical	EMORY									11	11	2000	12:20 A
niner 4a Fi	acility Nama (If I									cation of Death			
			town R				Indar 1 Yaar	Ber If Under 2		6 Date of Bird		ceste	
	279-34-	6298	6. Sex 1 <b>X</b> M 2□	) e	In yrs. last birt		nths Days	Hours	Min.	8. Data of Birt (Month, De 12/24	y, Year) /1934	9. Birthp Coun	leca (Stete or Foreign try) MD
-	Residence of D	10b. County		1	Oc. City, Town	or Location	1					11	0d. Inside City Limits
10e. 11. M	MD	Wo	rcester		Berli	in							1 ☐ Yas 2 🕱 No
10e.	Street and Num						f. Zip Code				10g. Citizen of	Whet Coun	itry?
	7866 Lib	pertyte	own RD				2181	1			US	A	
11. M	larital Status	d 💥 Marr	Arme	Decedent Eve ed Forces? Yes 2 No			Decedent of H specify Cube		in? (Spe Puarto	ecify Yas or No Rican, etc.)	- 14. Rac Bla	ca - Americ ck, White,	etc.
3	☐ Widowed 4	Divorced	Yaar	s, Give r or Dates:	Korea	101	es 22,3040	эреспу.			Specif	y: wh	nite
		15. Decedant by only highes	s Education	eted)	16a.	Decedent's (Giva kind o	Usual Occup of work done OT use retired	pation during most	of worki	ng	16b. Kind of B	usiness/Ind	dustry
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			Aydelot	te				Е	dna	Clarke			
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00-	Jeannii Method of Dispo		delotte/		20b. Plece of			town	RD	Berlin	MD 2 20c. Location	21811	wer Ctate
	Burial 2	Cremation			cemeter	y, cremetory	y or other plea						
12 17. Father's Neme (First, Middle Arthur Lee 19a. Informant's Name/Reletion 18a. Informant's Name/Reletion 18a. Method of Disposition 18a. Burial 2 Cremation 4 Donation 5 Other 21. Signatur Furreral Service				Cemete				Libert	-				
	signatur Hun	eral Service	Ucensee				ne and Addre		0		Funera		ne
					100	141:11:							
-	11 77	MIL	Justase	110	70/		Willian						
	Part1. Enter the shock, or heart	e disease, or failure. List	complications to only one cause	that caused the on each line.	p 74 / ne death. Do n							-1	Approximate Interval Between Onset and Death
150			complications to only one cause	that caused the on each line.		ot entar the	mode of dyin	ng, such as o	ardiac o	or respiratory a			Approximate Interval Between Onset and Death
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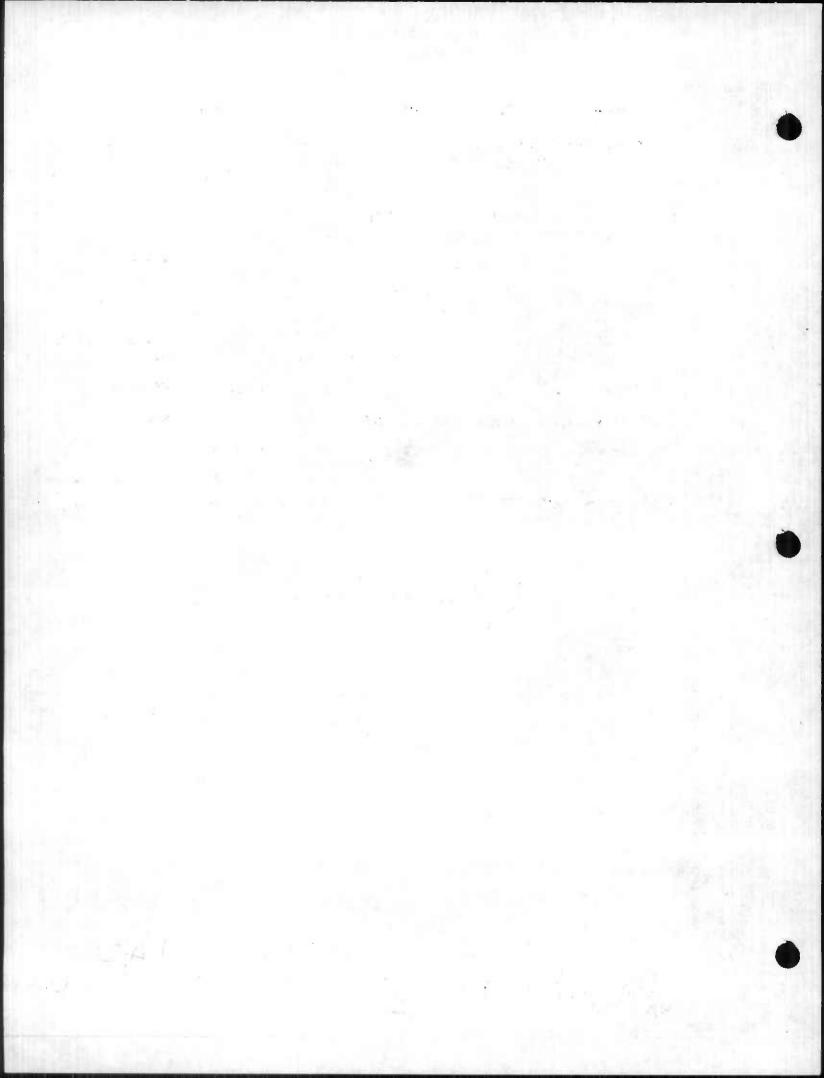
State of Maryland / Department of Health and Mental Hygiene 0 37350

			Cei	tificate of	Death	F	leg. No.	31330
Dharistan	1. Decedent's Nama (First, Middle, Las	()				2. Data of Dea Month		3. Time of Death
Physician /Medical	James	C.	Blume			Nov	04 20	000 0702
Examiner	4a Facility Nama (If not institution, give	street and number)		200	4b. City, Town, or I		4c. County o	f Death
	Southern Marylan			Williades 4 Vans	Clinton If Under 24 Hrs.			e George's
Funeral Director	5. Social Security Number 6. Security Number 11 11 11 11 11 11 11 11 11 11 11 11 11	1x 7. Aga (In yrs XM 2□ F 92	. last birthday) Yrs.	If Under 1 Yaar Months Days	Hours Min.	8. Data of Birth (Month, Day June 4	, 1908	Birthplace (Stata or Foreign Country)     North Carolina
pus *	10a. Stata 10b. County	10c. C	ity, Town or Lo	cation				10d. Insida City Limits
e Mary	Maryland Prince G	eorge's	Clinto	on				1 □ Yas 2)\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
ifer death with the Ma r items 23s or 28s-1s river must be notified Funeral Director	10e. Street and Number 881.3 Marquis I	ane		10f. Zip Code 20735			U.S.A.	het Country?
by Li.	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant Evar in U Armed Forcas? 1 [XYas 2 □ No If Yas, Giva Yaar or Datas] 955	1925-	Was Decedant of If Yas, specify Cub	Hispanic Origin? (S an, Maxican, Puart Specify:	pecify Yas or No- o Rican, atc.)	Black	- Amarican Indian, , Whita, atc. White
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D = 0 = m	James C.	Blume			Ir	ene	Ridenh	nour
S D E E	19a. Informant's Name/Ralationship (7		19b. Mailir	ng Address (Street	and Number or Ru			
alth ar	Beverly Blume (D	aughter)		8813 Marc	quis Lane	Clinton	, Maryla	and 20375
if Nem or oth	20a. Mathod of Disposition  1 ☑ Burial 2 ☐ Cramation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Ramoval from Stata	cematery, cran	sition (Nama of natory or other pla	Nov.	9, 2000		City or Town, Stata , Maryland
	21. Signature of Funaral Sarvice Licens			2. Nama and Addra		Lee Fune		
Demit. Depart Import any in	Douis L. H			ccoo ol 1				Linton, MD2073
rentificate be executed and use as the bunal-transit	disease or condition rasulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	· Acidosi · Cirrho	or as a consequence or as	juance of):	lic)			
death cer e attendir ed for use								
t the d	Part II. Other significant conditions co	entributing to death but not re	sulting In the u	ndarlying causa gi	ven in Part f.	23b. Dld t		tribute to the cause of death?  3 Probably 4 Unknown
a law requires the has been signed be 2 should be dempieted by							an autopsy med?	24b. Were autopsy findings available prior to complation of cause of death? N/A
certificate rector, pag	25. Was case referred to medical				26 Place of Dec	ath (Check only o		
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6 6 7	27. Manner of Death 1 Natural 5 Pending	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	f 28c. Inju			now injury occurre	
Attan or deat ector: by the	2 Accident invastigation 3 Suicide 6 Could not be 4 Homicide data mined		noma, farm, str			28f. Location (S City or Tox		er or Rural Routa Number,
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110	30 Name and address of person who d	complated cause of death (Its	m 23a) (Type,	Print)	of the la	MAINIA	Cill	- Maraza
	3h Dota Hakilaidan Constrant	130 19 IV	J. +	101701	19112 K	WILL	VIII)	MINATOR
State	MOV "WIND ZUU ON /	32. Registrar's elgr	Loca	Kal				

DHMH 16 Rev 6/95

BLUME, JAMES 11/4/00 0702 DR PATTERSON

ORIGINAL



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Tima of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 2, 2000 4:37 Am KIMBERLY E. BLANCHARD /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 1anham If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DOCTOR'S HOSPITAL Prince Georges' If Under 1 Yeer Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Funeral Deys 1 M 2 XF Yrs Director 214-19-7752 September 5,1975 New Jersey Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Directo Maryland Prince Georges' Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 6803 Storch Court 20706 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 Yes 2 No Specify Specify: q 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College 12th +02 student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Freddie R. Blanchard Johnnie M. Walltower and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) artment of Health a present: If Nem 27 Is Freddie R. Blanchard/father 6803 Storch Court Seabrook, Md. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 8, 2000 Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Northern Virginia Crematory Arlington, Va. 22. Name and Address of Facility Frazier's Funeral Home, Inc. 21. Signature of Funeral Service Light 389 R.I. Ave., N.W. Wash., DC 20001 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failura. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) RINAL FAILURE /Medical CHRONIC Examiner Due to (or as a consequence of) Examiner HYPERTENSONN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) Physician/Medicai Due to (or as e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SGI ZURE DIS pROOR by 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□ Yas 2 No 1 Yes 2 No Be 25. Was cesa rafarred to medicat 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 12 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Mannes-of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, this certificate has l or Attending Physician; after death. Director: /

To the Hospital within 24 hours a To the Funeral Completely filled

State Registrar

t Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier

MOV 0 7 2000

31. Dete filed (Month, Day, Year)

29a. Cartifiar

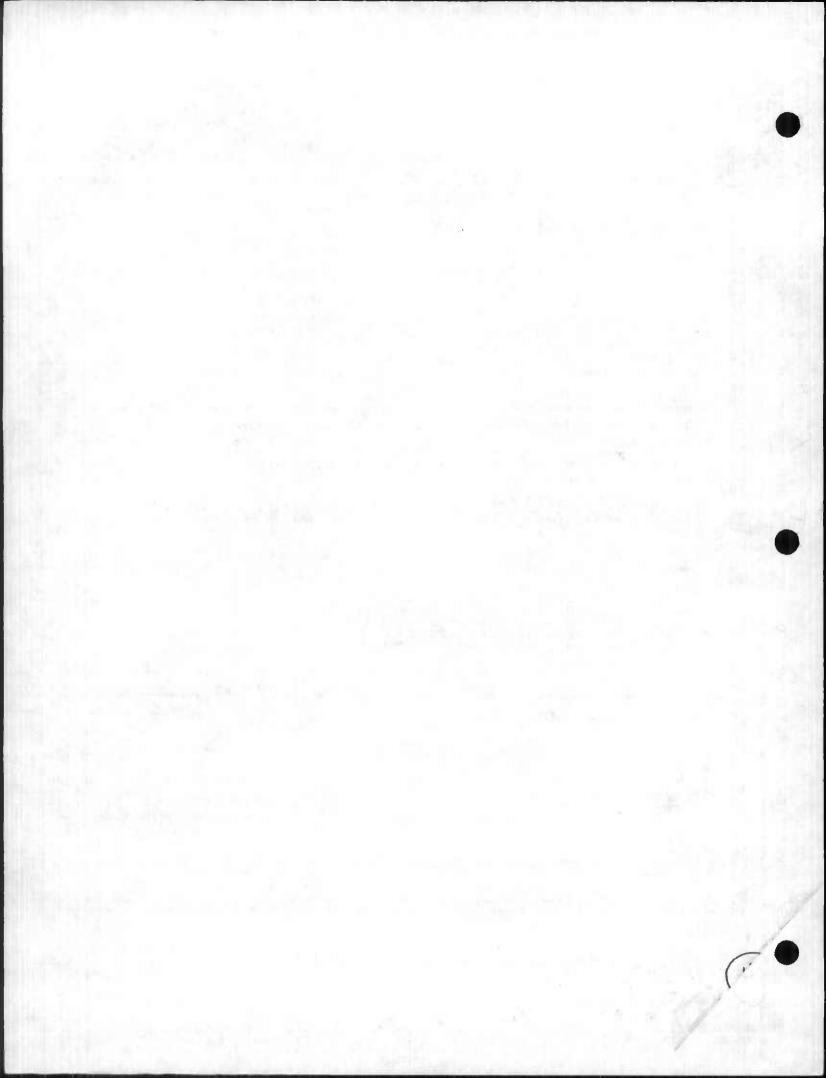
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29c. License number D41240 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

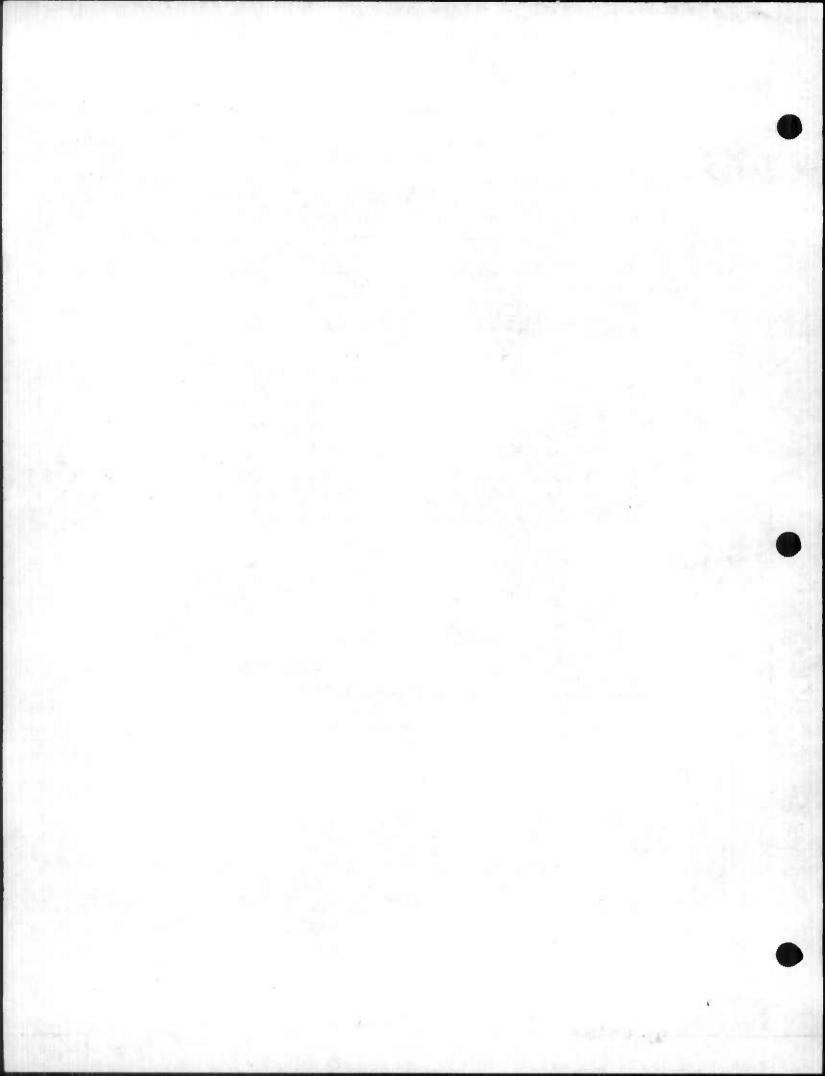
VIlle KOM 32. Registrer's Signeture

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Dev Year Month **Physician** FRANKLIN BENJAMIN BAYNES Nov. 2, 14:45 2000 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) 6 Sax 7. Age (In yrs. last birthdey) **Funeral** Days Months Hours 10XM 20 F 130-26-9966 78 Director October 6, 1922 Panama Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Stele 10b. County ral', or items 23a or 28a-f show Examiner must be notified at Yas 2□No Maryland Prince George's Upper Marlboro Directo 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 9706 South Shuttle Ct. 20772 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2√2 No If Yes, Give² Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, DEA 11. Meritel Status Bleck, White, etc. 72 hours after 1 □ Never Merried 2 □ Merried Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. þ 3\(\times\)Widowed 4 \(\Divorced\) "netural". Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natur traumatic avent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 4yrs. Draftman Private 18. Mother's Neme (First, Middle, Maiden Sumame) Dournant Pages 1 and 2 should be file Dournant of Health and Mental Hy Important. If them 27 is merked other any Injury or other traumatic avent pages. 17. Father's Neme (First, Middle, Last) Be Ralph Baynes Ruth Elizabeth Goodings 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Lisa Baynes / Daughter 9706 South Shuttle Ct. Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3X Removel from Stete 11-7-00 New Bedford, MASS. 4 ☐ Donetion 5 ☐ Other (Specify) RURAL CEMETERY 22. Name and Address of FacilityMarshall's Funeral Home of MD 21. Signeture of Funerel Service Licensee 4308 Suitland Rd. Suitland, MD 20746 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Condiac_ Examiner Due to (or es a consequence of): END STAL Examine attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Sept lana Physician/Medical Due to (or es e consequence of): igned by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown kq peubis þ 24a. Wes an autopsy performed? 24b. Were autopsy findings eveilable prior to Completed completion of cause this certificate has 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medical axaminer? funeral director, Be 26. Place of Death (Check only one) Hospitel: 1 ☑ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 ☑ No 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menyfer of Death 28b. Time of 28c. Injury et Work? Certification: After t 1 MNeturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 4 Homicide ŏ To the Hospital
within 24 hours a
To the Funeral Countyletely filled Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner as steled.

Purpose Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number mp. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khos row Da Vach / 1328 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State Registrar DHMH 16 Rev 6/95 **ORIGINAL** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

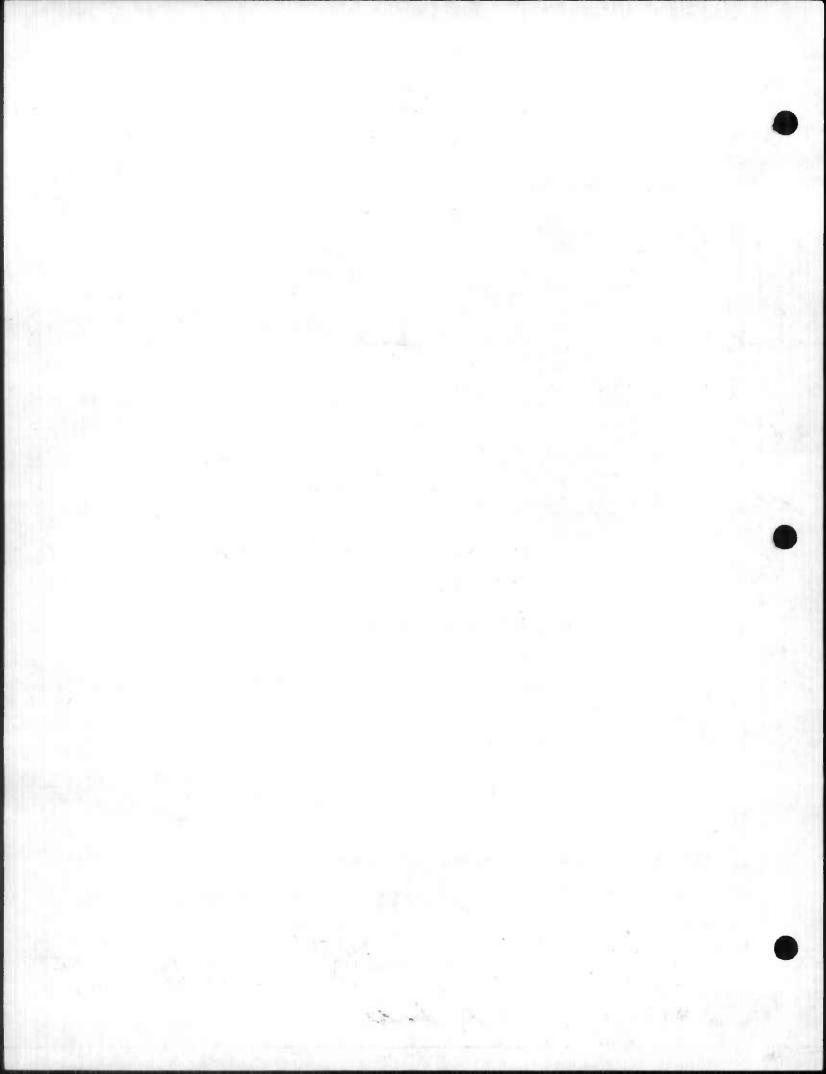
State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death BLACKWELL Month **Physician** WILLIAM 640 AM 01 2010 11 /Medical 4e Fecility Neme (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CHEVERLY PRINCE GEDRGES GEORGES CANTER If Under 24 Hrs. B. Defie of Birth Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** MOM 2DF Director 240-36-2641 North Carolina Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Capitol Heights Yas 2 No Director 28a-f Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 82 400 Quarry Avenue 20743 USA Funeral 11 Marital Status 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yas, Giva 1 ☐ Never Married 2 ☑ Married b 21215-0020 1 ☐ Yas 2 TNo Specify: Specify: Black. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Contractor Baltimore, Maryland 17, Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) mit. Pages 1 and 2 should be file partment of Health and Mental Hi portant: If flem 27 is marked oth I fejury or other traumedic even Be Robert Blackwell Elma Haywood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Zenobia Moon Blackwell 400 Quarry Ave., Capitol Hts, MD 20743 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) 11/6/00 Clinton, Maryland Resurrection Cemetery 21. Signature of Funeral Service Licenti 22. Nama and Address of Facility Pope Funeral Home 5538 Marlboro Pike, FV., MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. M01085 Approximate Interval Between Onset and Death **Physician** MaltoRGAN SYSTEM FAILURE /Medical Immediata Causa (Final 5 weeks disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequance of): Box 68760, exem Physician/Medical Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. signed by the 1 Yes 2 No 3 Probably Actinknown I'NEw mours Division of Vital Records, Be Completed by SUDSWAL bematouch 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CALSOMYPAThe 2 5 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To this 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospital of within 24 hours at To the Funeral D The control of the best of my knowledge, daath occurred at tha time, date and place, and due to the cause(s) and manner as stated.

If the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai ampletely 29b. Signature and title of conting 29c. License number 29d. Data signed (Month, Day, Year) 20051485 6 causa of death (Item 23a) (Type, Print) 1922 TWINLAKES
ACCIAIN BEZTSVILLE MD

Registrar

31. Dete illed (Month, Day, Year) NOV 0 6 2000

MALA



**Funeral** 

Director

"natural", or items 23a or

d 2 should be tiled within 72 hou th and Mental Hygiene. ?? Is marked other than "natural traumatic avant, to Miss or E 1 and 2 should be Health and Mental 19a. Informent's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Itam 27 Is any Injury or other tra Patricia Shrader - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 11-8-00 4 ☐ Donation 5 ☐ Othar (Specify) Hagerstown Crematory 21. Signature of Lineral Servica Licenses 22. Name and Address of Facility Missel **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Lardio myocaraca in Examiner Due to (or as a consequence of): Examine sician and burial-transit alheronever that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the Due to (or as a consequence of): 50 use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records. þ The law requires Completed certificate has Division of Vital Attanding Physician: funeral director, 25. Was case referred to medicat examiner? Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 1 Matural 5 Pending death. 1 Yes 2 No investigation 2 Accident within 24 hours after deal To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ò Hospital Medical 29a. Certifian (Check only

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Dey}7, 2000 **Physician** Frances Ellen BROWN November 2:05 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeder Memorial Home Boonsboro Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) 1 M 2 F Months Days Hours Yrs. 214-09-6802 85 Feb. 8, 1915 Maryland Usual Residence of Decadent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18819 Preston Road 21742 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify þ white 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Harry S. Kelley Katherine Gruber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 Link Rd., Silver Spring, Md. 20905 20c. Location - City or Town, State Hagerstown, Maryland MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervat Between Onset and Death minuel 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, State) **Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifian 29c. License number 29d. Data signed (Month, Day, Year) D 32518 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/301-432-2222

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

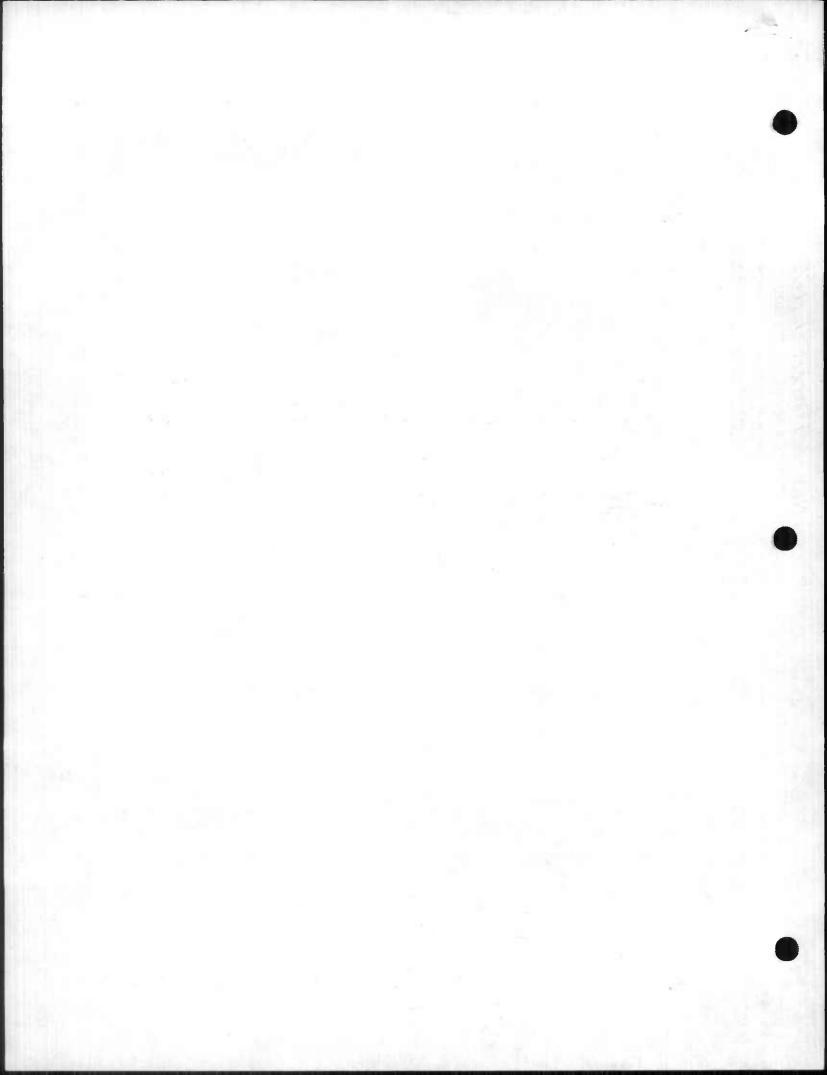
State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death

**DHMH 16 Rev 6/95** 

State Registrar

the

32. Registrer's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last, 2. Dete of Deeth 3. Time of Death Month Rebecca Jane Burkholder November 2000 8:45 a.m. 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Homewood Nursing Home Williamsport Washington 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months | Deys | Hours | Min. | (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) 1 M 2 KF Deys Yrs. 220-16-2196 Nov. 10, 1905 West Virginia Usuel Residence of Deceden 10e. Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 366 S. Cannon Avenue 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 Divorced Specify: White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 homemaker home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Alvey Worthington Mary Catherine Womac 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Elwood M. Burkholder, Jr. Son 16722 Tammany Manor Road Williamsport, Maryland 21795 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriel 2 Cremetion 3 Removei from State Rest Haven Cemetery 11/11/00 Hagerstown, Maryland 4 □ Donetion 5 □ Other (Specify) ature of Funeral Service Licensee 22 Name and Address of Facility Ch 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 23a. Part1. Enter the diseese, or complications that caused the shock, or heert failure. List only one cause on each line. Do not enter the mode of dylng, such as cardiac or respiratory errest, Approximete Interval Betw Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or Injury that initiated exects.) Due to (or es e consequenca of): Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2 No 3 Probably 4 Unknown - savere. val vascular disease 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 20 No 27. Manner of Deat 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

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Physician /Medical

Examiner

State

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Registrar

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29b. Signature and tale of signature

29a, Certifier

completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

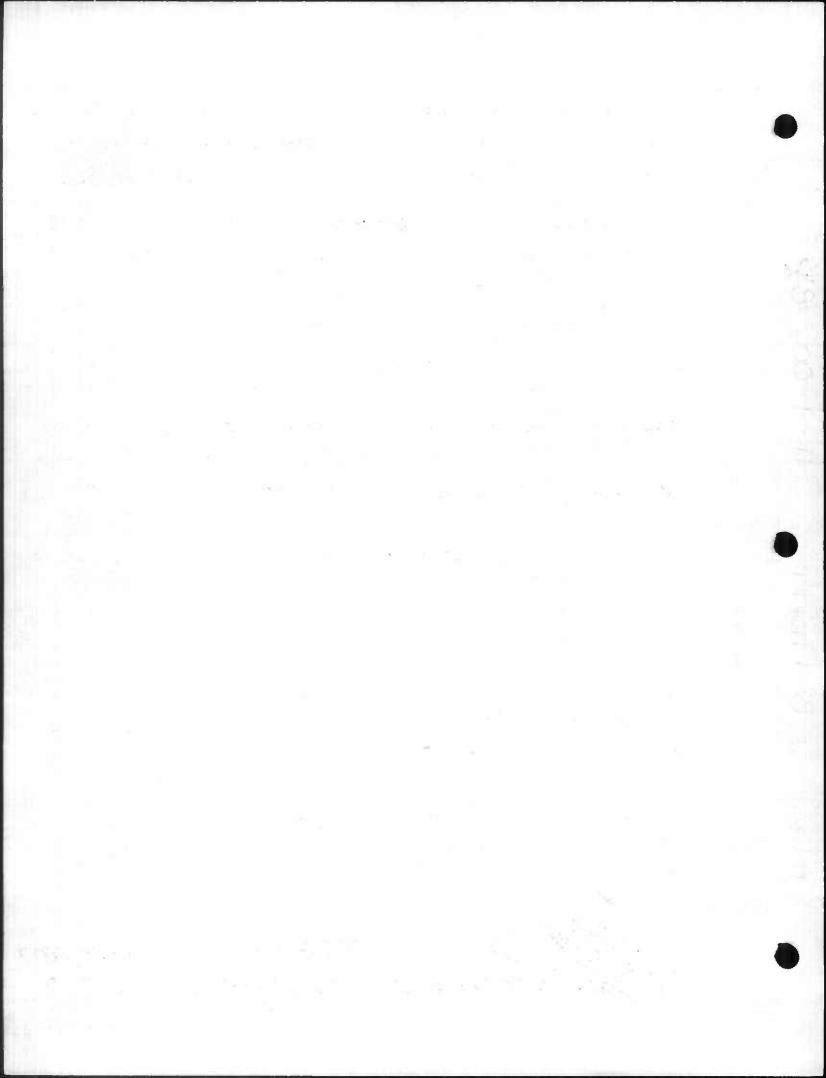
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Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29c. License number

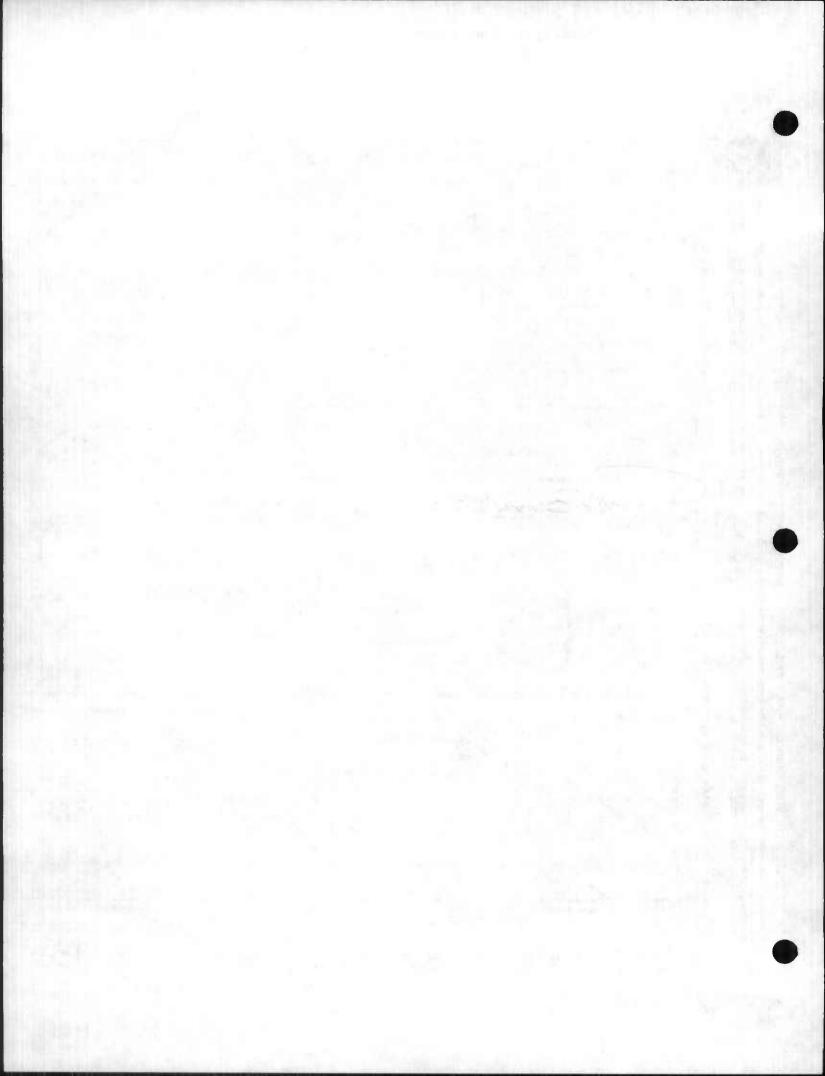
29d. Dete signed (Month, Day, Year)

To the Hospital o within 24 hours at To the Funeral D



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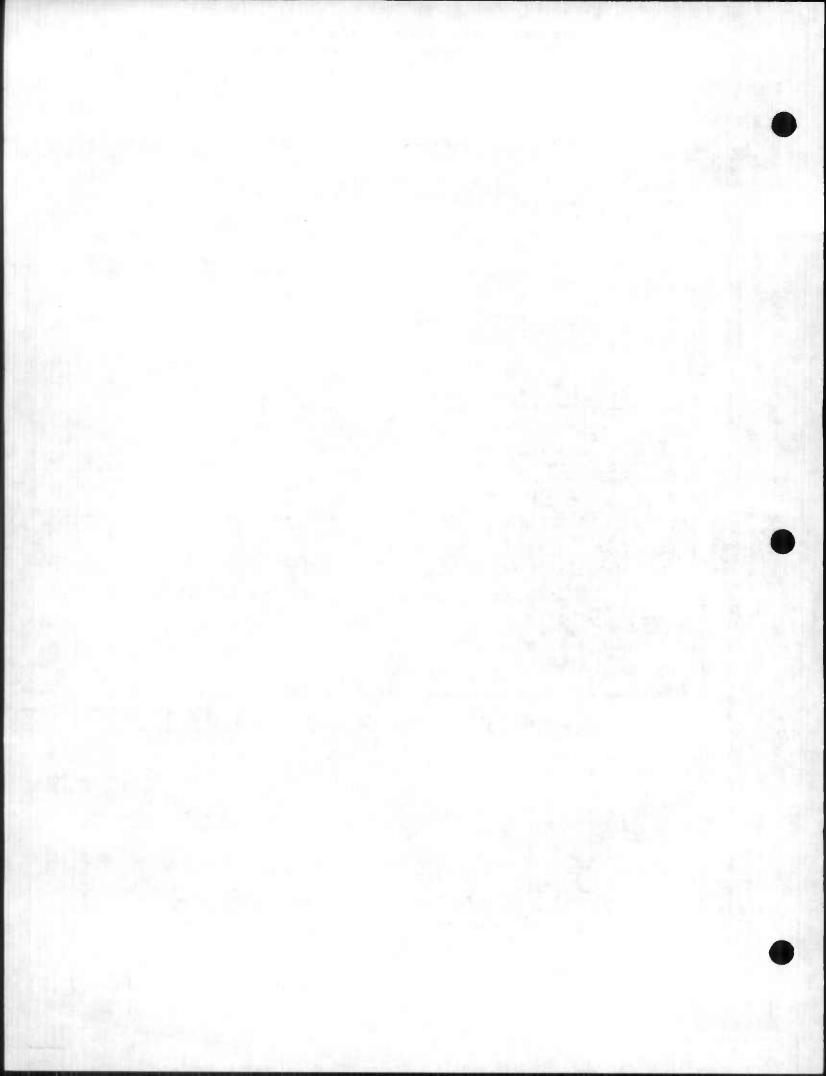
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Funeral Director	1	. Sociel Security Number 021–22–4386		x □M 2 <b>X</b> ↓F	. Age (In yrs. 72	last birthday) Yrs.	if Under 1 Yea Months Deys					thplece (State or Foreignuntry)
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State of Maryland / Department of Health and Mental Hygiene 3 7 3 5 7

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iner	4a F	acility Name (If not institution	on, give street end n	um <i>ber)</i>			4b. City, Town, or				
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	5. Sc	ociel Security Number	6. Sex 1X□ M 2□ F		yrs. lest birthdey	If Under 1 Ye   Months   Da	ear If Under 24 Hrs	8. Date of Birt	r, Year)	9. Birthplece (S Country)	
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State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Year **Physician** FRANCIS A. BANKARD 5:35 pm NOVEMBER 7 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death # Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6/29/1919 Examiner CECIL VA MARYLAND HEALTH CARE SYSTEM 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** Months 10 M 2□ F Days 213-18-1231 81 Yrs. Director MARYLAND Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No CARROLL MD. SYKESVILLE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 421 KLEE MILL RD. 21784 USA. 12. Wes Decedent Ever in U,S. Armed Forces? 1 (X/Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Merried 2 Married Specify: WHITE 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) MECHANIC MANUFACTURING Maryland 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental h is marked off HARRY BANKARD KATHLEEN McGINITY 19e. Informant'a Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tr 421 KLEE MILL RD., SYKESVILLE, MD. 21784 VIOLET BANKARD - WIFE Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Pages nant of h 1 ₺ Burial 2 □ Cremetion 3 □ Removel from State BETHESDA CHURCH CEM. 11/10/00 SYKESVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility FLETCHER FUNERAL HOME 21. Signeture of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. 21157 now 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart lailure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) ALZHEIMER'S DEMENTIA UNKNOWN Examiner Due to (or as a consequence of) physician and the burief-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or ea a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Onknown SEIZURE DISORDER þ Records, 24b. Were autopsy lindings evailable prior to completion of cause of death? 24e. Wes an eutopsy parformed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation il or Attendin i after death. i Director: Aft 1 Tyes 2 No 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28l. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, lectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA MARYLAND HEALTH CARE SYSTEM PERRY BINT, MD 21902 M.D. MELECIA SANTOS

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

**DHMH 16 Rev 6/95** 

State

Registrar

31. Dete filed (Month, Day, Year)

32. Registrar/s Signature

Deneva

NOV 13 2000 >

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REGIS BURKET

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State of Maryland / Department of Health and Mental Hygiene

. /	Department of	1	icallii allu	MICHIGA
	Certificate o	f	Death	

**Physician** /Medical Examiner

Regis Ferdinand Burket IV 4a Facility Name (If not institution, give street end number)

2. Data of Death Month Day Ye NOVEMBER 9, 2000

Feb 7,1982

3. Tima of Death 10:38P.M.

SHOCK TRAUMA CENTER

1. Decedent's Name (First, Middle, Last)

4b. City, Town, or Location of Death BALTIMORE

4c. County of Death

**Funeral** Director

re 23a or i

b

filed within 72 hours sher

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Baltimore, Maryland 21215-0020

Funeral

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Completed

Be

Physician/Medical Examiner

by

Be Completed

paga

Aftar this

Director: /

death.

after

To the Hospital within 24 hours a To the Funeral Completaly filled

056-72-2118

187M 2□ F 18 Yrs.

7. Age (In yrs. lest birthday)

If Under 1 Year | If Under 24 Hrs. Days Hours

 Birthplace (State or Foreign Country) Florida

Usual Residence of Decedent

5. Social Security Number

10a. State 10b. County Carroll

10c. City, Town or Location

Reisterstown

21136

10d. fnside City Limits 1 ☐ Yas 2 X No

Director Maryland 10e. Street and Number

2329 Emory Road

10f. Zip Code

10g. Citizen of What Country?

USA

11 Marital Status

1 1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yas 2 No Specify:

14 Race - American fodian Black, White, etc.

18. Mother's Name (First, Middle, Maiden Sumeme)

white

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)

16b. Kind of Busineas/Industry

12

Student

School

17. Father's Name (First, Middle, Last)

Regis F. Burket III

Patricia Lee Snyder

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)

2329 Emory Road, Reisterstown, MD 21136 20c. Location - City or Town, Stata

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Regis Burket III, father

20b. Place of Disposition (Neme of cametery, cremetory or other pleca) Carroll Cremations

2000 Hampstead, MD 11/13

21. Signature of Funeral Servica Licansee 20

MO@723 al cl

22. Nama and Address of Facility

Eline Funeral Home 934 South Main St, Hampstead, MD 21074

**Physician** /Medical **Examiner** 

phys the

The law requires that the death certificeta be executed

Box 68760,

P.O.

of Vital Records.

Division

Hospital or Attending

any is

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last

fmmediate Cause (Final disease or condition resulting in death)

Due to (or as a cons quence of):

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequenca of)

Dua to (or as a consequence of)

Part If. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contribute to the cause of death? 1 | Yaa 2 No 3 | Probably 4 | Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to

Approximate tnterval Between Onset and Death

2 No

completion of causa 1 Ves 2 No

25. Was case referred to medical examiner? TV Yas 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

Hospital: 5 Pending investigation

1 ☐ inpatient 2 X ER/Outpatient 3 ☐ DOA 28b. Time of Injury 7:46 PM 00

28e. Piece of fnjury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☑ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Driver, oF

111 Penn Street, Baltimore, Maryland 21201

Vehicle roto Location (Street and Number or Rural Routa Number, City of Town, State) Object Md lanchetter

Medical Certification: To 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mahner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number 29b. Signature and rateros certifier

Staner

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treet

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year)

of person who completed cause of greath (Item 23a) (Type, Print)

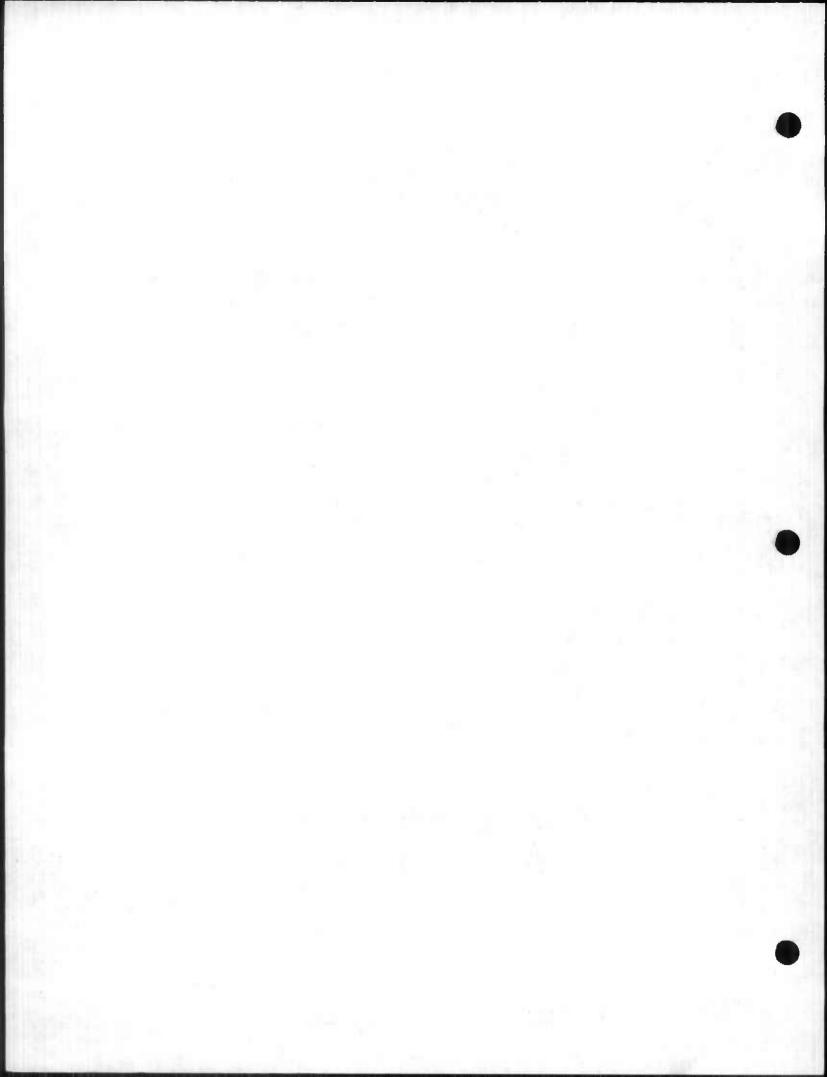
6 Could not be determined

O.C.M.E.

NOVEMBER 10,2000

State Registrar Joseph NOV 13 2000

32. Registrar's Signatura Deneva



				i lease	Type or Pri		/ Depa		of H	ealth and M	lental Hy	()7)		37360
			1. Decedent's Nan	na (First, Middla, Last	)	- 1		imouto	0, 2	704177	2. Date of De	ath		3. Time of Death
	Physici			HERE	BERT WOO	DROW	BEAV	ER			NOV.	5, 2000	Yaar )	6:30 PM.
	/Medi Examir		4a Facility Name	(If not institution, give	street and number)				41	o. City, Town, or Lo	ocation of Deat			
			GLADE V	ALLEY NU	RSING &	REHA	AB. C	TR.	W	ALKERSV	ILLE	FREDI	ERI	CK
	Funeral Director		5. Social Security I	-0521	x 7. Ag JM 2□F	a (In yrs. las	st birthday) Yrs.	If Under 1 Months	1 Yaar Days	Hours Min.	8. Data of Bir Month, Da 9 / 2 / 1 9	th ly, Year) 18	Co	hplace (State or Foreign unity) YLAND
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	with the Maryland a or 28arf show Lbe notified at	10	MD.	CARROLI		FINKS	BURG	;						1 ☐ Yas 2) No
	The Mary	Directo	10e. Street and Nu					10f. Zip (	Coda			10g. Citizen of W	hat Co	untry?
	Se or	D	2769 K	AYS MILL	RD.			2	104	8		USA		
	death Lima	nera	11. Marital Status		12. Was Decedent	Evar in U,S.	13.	Was Deceda	ant of His	spanic Origin? (Sp	ecity Yes or No	- 14. Race		rican Indian,
0	or he mine	3	1 Nevar Mar	ried 2∑ Married	Armed Forces? 1 ☐ Yes 2 ☑			_		Mexican, Puerto	Hican, atc.)		k, White	
02	hours after bursi', or its at Examina	by	3 Widowed	4 Divorced	If Yas, Giva Year or Dates:			1⊡ Yas 2 ₃	X NO	Specify:		Specify:	WH.	LTE
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121	and	Compl	Elementary/Sec	ondary (0-12)	Collega (1-4or	5+)		DO NOT USE UNTER				LUMBER	) CI	2
Maryland 21215-0020	Hydie Hydie H, H		17. Father's Name	(First, Middla, Last)				ONIE	K CI	18. Mothar's Name	e (First, Middle			J •
an	hental head of the eve	o Be			. BEAVE	R					IE A.		,	
J.	M by	70	19a. Informant's N	Name/Ralationship (7)			19b. Mailir	ng Addrass	(Street a	nd Number or Rur	al Routa Numb	er, City or Town,	Stata, 2	Zip Code)
ž	277 a 277 a 478 a		NORA BE	AVER	- WIFE		2769	KAYS	S MI	ILL RD.	, FINK	SBURG,	MD	. 21048
Baltimore,	Pages 1 a ent of Ha nt: If Illam ry or othe			sposition Cramation 3		cen	netary, crat	sition (Naminatory or oth	har place	ARDENS1	Data 1 / 9 / 0 0	20c. Location -		
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			23a. Part1. Entar	tha disease, of comp art tailura. List only o	lications that caused	d tha death.	Do not ent	ar tha moda	a of dying	, such as cardiac	or respiratory a	rrast,	1	Approximate Interval Between
$S_{\lambda}$	Physician		SHOOK, OI HE	art tailora. List orny o	10000	0								Onset and Death
	/Medical Examiner		Immediata Causa disaase or conditi	on	. Uls	her	Mes	ا کر	de	rease	_		1	years
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Вох	leath certifical attending ph of or use as to	Physician/M			d									
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of Vital Record	been should	Completed										an autopsy ormed?		Were autopsy tindings available prior to complation of cause of daath?
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>	5 00	TOE	examiner? 1 ☐ Yas	S'No	Hospital:	ant 2DE	R/Outpatie	nt 3 DO	A Othe	Pr: 45 Nursing Ho	oma 5□Ras	idanca 6 Othe	er (Spe	city)
ion o	Afte fune		27. Manner of Des 1 Natural 2 Accident	5 Panding invastigation	28a. Data of Inju (Month, Da	ly Year) 2	8b. Time o Injury	M 28	8c. Injury Work 1 🗆 `	rat (? res 2□No	28d. Describe	how injury occurr	ed	
Division	after death. Director: A	ertification:	3 ☐ Suicide 4 ☐ Homicida	6 Could not be datamined	28a. Placa of In building, al	jury - At horr ic. (Specify)	na, farm, st	reet, factory,	, offica			(Streat and Numb wn, Stata)	er or R	ural Routa Number,

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

1 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

2 Section 1 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Description 2 Section 3 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Description 3 Section 3 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

AluTuk

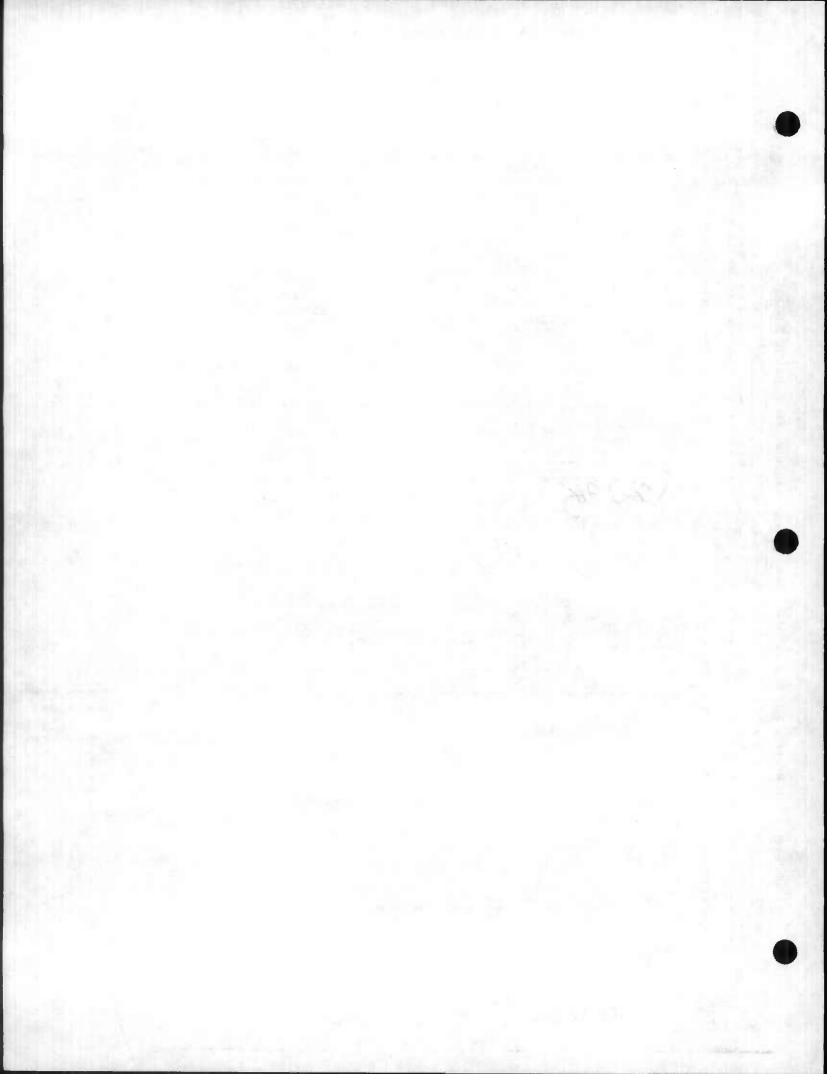
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29d. Date signed (Month, Day, Year)
NOVEMBER 7 2000

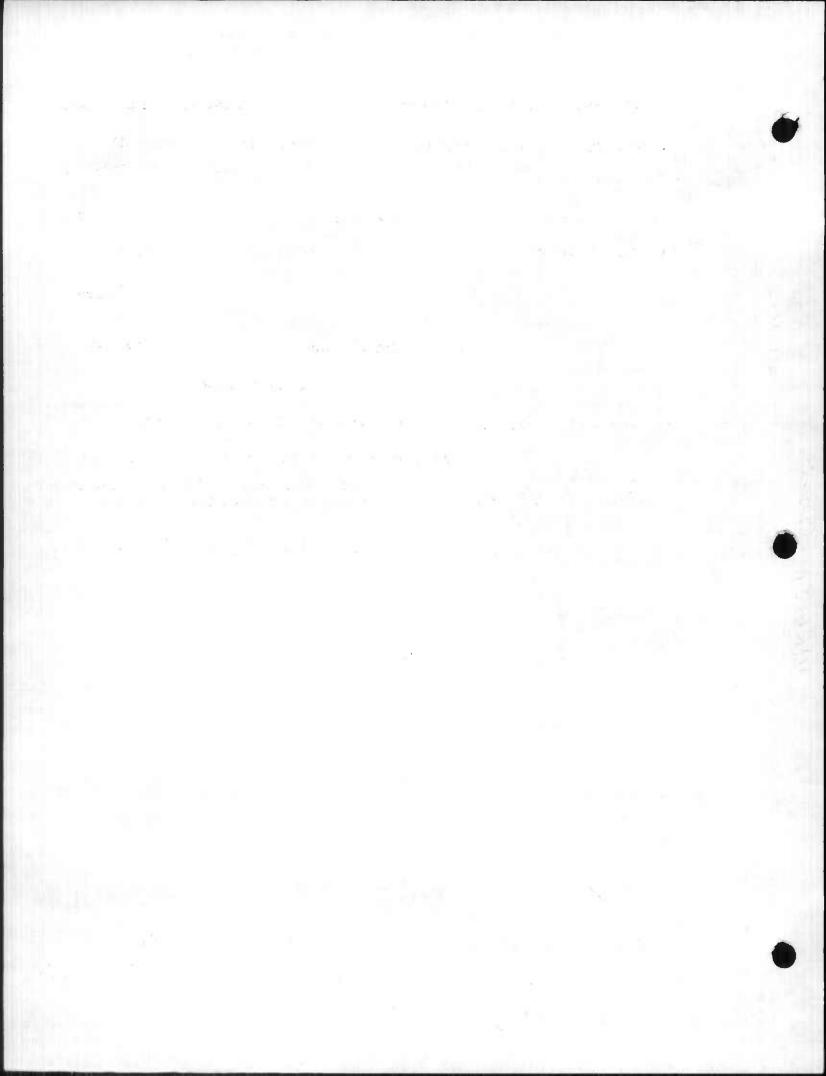
Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

FLENERKIND 21702

State Registrar



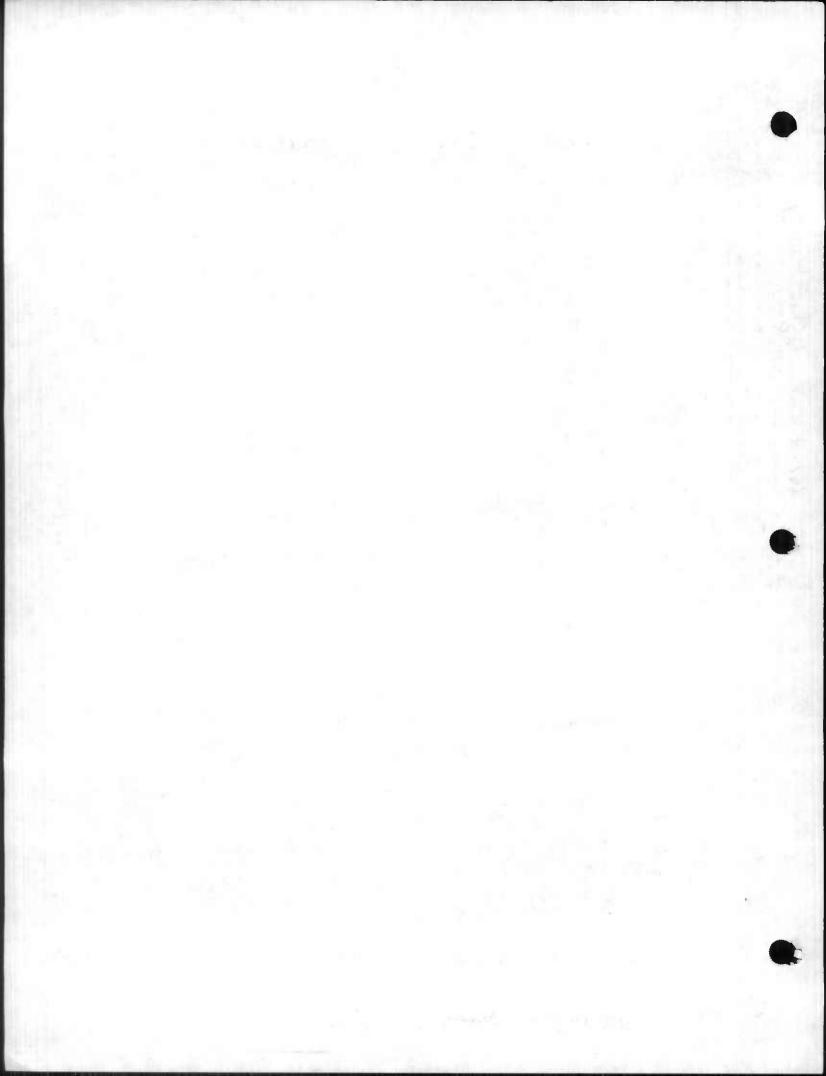
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~	/Media				va street and number		WCLD		4b. City.	Town, or L	ocation of Deal			
	Examir	ıer	Manager 1				-1			tmin		Carr		
	Funeral Director		5. Social Security N 216-22-4	lumber 6.	General Sex 7 1□ M 2ÅD F	Age (In yrs. le	ast birthday, Yrs.	Months Da	ar If Unda	ar 24 Hrs.		rth Yaar 1918	9. Birth	place (Stata or Foreign into Land
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	nylan		10a. Stata	10b. County		10c. City	Town or L							10d. Inside City Limits
	Pe Me	Director	MD	Carro	11		Syk	esville						Yas 2□No
	with the Maryland a or 28a-f show be notified at	ä	7309 Sec	mber ond Aven	110			10f. Zip Cod	la 2178	84		10g. Citizan of \	What Cou	untry?
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	after dee	F		ied 2 Married	Armed Forca	s?		Was Decedant			Rican, atc.)	Blac	ck, White	
	5-0020 72 hours after death with the Manyland instural", or items 23s or 28s-f show dipsi Examiner must be notified at	by	₩idowed	4 Divorced	If Yas, Giva Yaar or Data	s:		1□ Yas 2⊉	No Specif	y:		Specify	/: VVI	irce
	15-002 72 hours	etec	(Spec	15. Dacedant's E	ducation rade complated)		16a. Dece (Give	edant's Usuel Oc a kind of work do DO NOT usa ra	cupation na during me	ost of worl	king	16b. Kind of B	usiness/l	ndustry
	aryland 21215 should be filed within 72 and Mental hygiene. s marked other than "numatic event, the Mental	Completed	Elementary/Seco	ondary (0-12)	College (1-4d	or 5+)		eteria				Food S	Servi	ice
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	lan id be lental ked c	To Be	Sterl	ing G. L	eppo				Ali	ce R	ichards			
	Maryland 21215-0020 d 2 should be filed within 72 hours aft in and Mantal hyglene. 7 Is marked other than "natural", or traumatic event, the Medical Example.		19a. Informant's Na	ame/Ralationship	(Type, Print)		19b. Mail	ing Addrass (Str	aat and Num	ber or Ru	ral Route Numb	ber, City or Town,	Stata, Z	ip Code)
	end 2 saith n 27 l		Mrs. Kay	e Jenkin	s (Daught					Syke	sville,	MD 2178		
. ^	Ore 1 there or out		20a. Mathod of Disp		Removal from Sta	Ce	matary, cre	osition (Name of ematory or other	placa)	1	Data /7 /00	20c. Location		
2	Baltimore, semit. Pages 1 er separtment of Hea moortant: If item 2 nry Injury or other note.		4 Donation	5 Other (Special	ify)	Eve		n Memor		1		Finksbu		
30wers	Baltimore, Maryland permit. Pages 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, once.		21. Signature of Fu	. /	d/a - //	+	2	HAIGHT	dress of Fac FUNERA	L HO	ME & CH	APEL, PA	A (Bo	ox 195)
00		$\Box$		and of.	Many C	ad the death	Do not en	Sykesv	ille,	MD 2	1784 (4	10)-795-	-1400	Approximata
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4	Examiner		rasulting in death)	л	a			quance of):			V			
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	ords, P.O. requires that the de										10	Yss 2□ No	3 🗆 Pr	obably 4 Unknow
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	o P		27. Manner of Deat	h	28a. Data of li	-	28b. Tima (		njury at Work?	ruising ri		how injury occur		ney)
	onding seth.	atio	1 → Naturel 2 □ Accident	5 Pending Invastigation	on	Day roar)	Hijury		1 Yas 2	□No				
	ivis r Atte ter de lrecto	Certification:	3 ☐ Suicida 4 ☐ Homicide	6 Could not I	Zoa. Flace of	Injury - At hor etc. (Specify)	ma, farm, si	traat, factory, off	ice			(Street and Numi own, Stata)	ber or Ru	ral Route Number,
	Division of To the Hospital or Attending Phy within 24 hours shier death. To the Funeral Director: After this completely filled in by the funeral		29a. Certifier	4776-111-1	To do to		In death door							-1-1-1
	Hos 24 ho Fun Fun	edical	(Check only one)	2 Medicat Exa	hysician: To the bes miner: On the basis and manner	of axaminati	on and/or Ir	nvastigation, in n	a tima, data ny opinion, d	eath occu	rred at tha time	, date end plece,	and due	to the cause(s)
	To the	Me	29b. Signatura and	titla of certifier				29c, Lic	ensa numbe	r		29d. Date signe	d (Month	n, Day, Yaar)
-			1 Ro	le o	7. Mo	, ,	NO		328			11/6		
			30. Name and eddr		complated causa o	daeth (Item	23a) (Type							2000, Md
	Sta	ite	31. Date filed (Mon			strar's Signati	ura							0,7,30
	Registr	ar		NOV 08;	2000 5	epera	19	800	uls)					



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State of Maryland / Department of Health and Mental Hygiene 37362

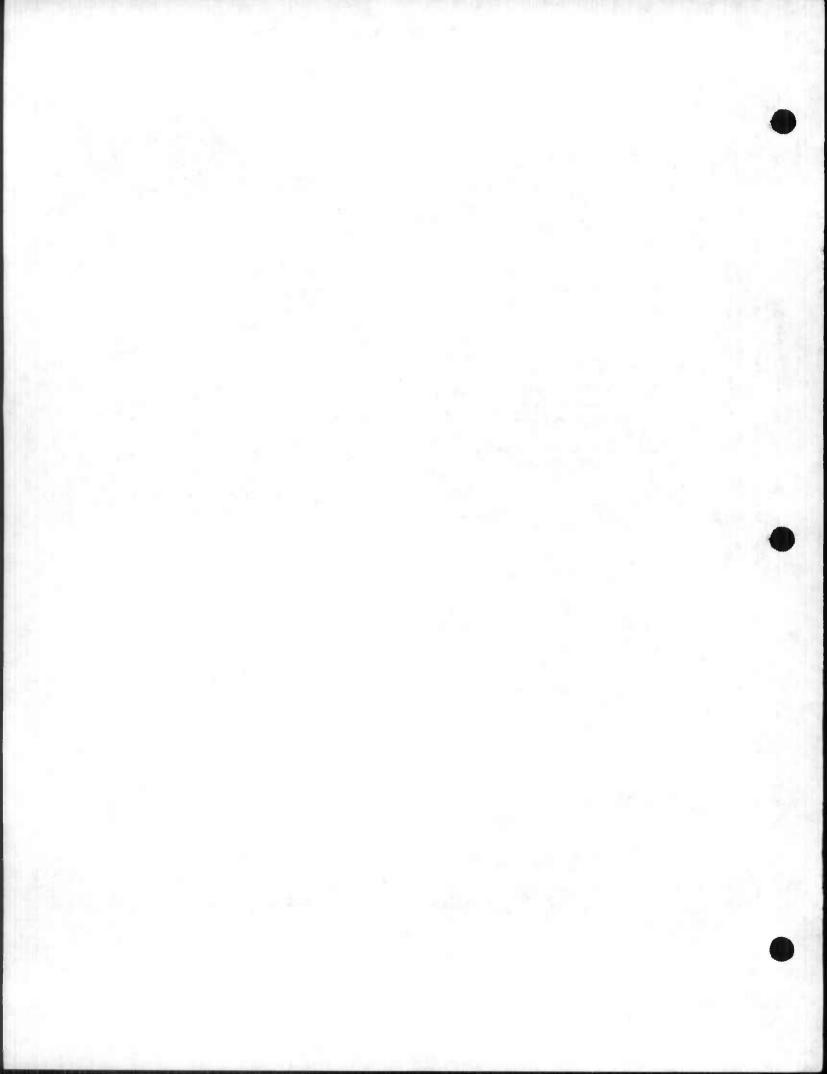
			Certi	ficate of l	Death		Reg. No.		
	1. Decedent's Neme (First, Middle, Last)	THE STREET				2. Dete of De	eath Day	Year	3. Tima of Death
Physician /Medical	James Fr	ancis Brady		PERMIT		Nauem			2250
Examiner	4a Facility Neme (If not institution, give s	street and number)		4	b. City, Town	or Location of Deat	h 4c. County	of Death	
·	Sinai Haspital	of Ballemoy			Balt	more City		1131	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. la	of puritings //	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bir Month, Da Aug • 2	th ly, Year)	9. Birthplac Country	ca (State or Foreign
Director	Usual Residence of Decedent	30	115.			nug. 2	1344	rid.	
hend	10a. Stete 10b. County	10c. City,	Town or Local	tion		4477		100	d. Inside City Limits
on the Maryler rate and rector	Md. Carroll	Har	mpstead						1 Yes Z No
offer deeth with the Maryland of Nerra 23a or 28a-f show when must be notified at Funeral Director	10a. Street and Number 4308 Wolf Hill Dr	ive	4-17	10f. Zip Code 2107	4		10g. Citizen of V	Vhat Country	y?
£ 2	11. Marital Status	2. Was Decedent Ever in U,S	. 13. Wa	s Decedent of H	ispanic Origin	? (Specify Yes or No		e - American	Indian,
Urs s	1 Never Merried 2X Merried 3 Widowed 4 Divorced	Armed Forces?  1 X Yes 2 No 1962  If Yes, Give Year or Dates: 1966	2-		n, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)		white White	c.
15-00.	15. Decedent's Educ		16a. Deceden	t's Usual Occup	ation dunna most of	f working	16b. Kind of Bu	siness/Indu	stry
	Elementery/Secondary (0-12)	College (1-4or 5+)		d of work done of NOT use retired			State H	ospita	1
d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2	17. Father's Name (First, Middle, Last)					Neme (First, Middle	, Maiden Sumam	10)	
yland be file Mentel Hy serked other stic avant	James F. Br	rady			Joan	Unknown	last pam	ne .	
aryl should me merk	19a. Informant's Name/Relationship (Typ		19b. Meiling	Address (Street		or Rural Route Numb			Code)
Malth alth	Vicki Lynn Brady (	(Spouse)	4308 W	olf Hill	Dr. H	lampstead,	Md. 210	74	
Baltimore, Maryland 212 semil. Peges 1 end 2 should be filed withi Department of Health and Mentel Hygiene. Important: If item 27 is mericed other than any injury or other treumstic avant, the M ance.  To Be Comp	20a. Method of Disposition 1 ⊠ Bunal 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	20b. Pia ce Gar	aca of Dispositi metery, cremal TISON	on (Name of tony or other place COTEST C	emeter	Date y 11/14/0	20c Location - O Garris	City or Town	n, State
Balti Semil. Separtr Mports any Inju	21. Signeture of Funerei Service License	00	22. N	lame and Addre	ss of Facility	ht Funera	l Home &	Chap	el
M 88 5 8	Harry 10 >	Haidt	P.0	).Box 19	5 Syk	esville,	Md. 2178	34	
	23a. Part 1. Enter the disease, or complice shock, or heart gallure. List only on	cations that caused the deeth.	Do not enter	the mode of dyin	g, such es ca	rdiac or respiratory e	errest,	1 6	Approximate nterval Between
Physician									Onset and Deeth
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Hypaxio	2	to pu	Ruon	ory Con	lusion	15	days
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d d ansit	Sequentially list and divine	CHEST	INJVR as a conseque					1	
68760, licate be executed physician and s the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.00 (0.00)		Man wife -		1/1	1	20	
rificate be example physician a set the burial.	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a conseque	nce of):		X	VIII.	MINER	71.17
T 2 2 5					CERT	IFIC GON APPROVED	BY MEDICAL EACH		
Box eath cer ettendin for use	d						Made		
	Part II. Other eignificant conditions conf	tributing to deeth but not resul	ting in the unde	erlying cause giv	en in Part i.	23b. Did	tobacco uee co	ntribute to t	the cause of death?
P.O. that the de by the detached detached	Renal failure	Concestul	heart	buler	,	1 🗆	Yee 2000	3 Probe	ibly 4 Unknown
Division of Vital Records, F or Attanding Physician: The law requires that after death.  Director: After this cardificate has been signed if in by the funeral director, page 2 should be detertification: To Be Completed by P ertification: To Be Completed by P	1:12	Congestul	11			24a. Wa:	an autopsy	24b. Were	e autopsy findings
y requ	diabetes melle	tes, ruper	Cerstan	~		perf	ormed?	evail	lable prior to pletion of cause seth?
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/ital	25. Was case referred to medicai				26 Place of	Death (Check only		1 10	165 2/0(10
raicia direct	examiner?	ospital: 1 Inpatient 2 E	R/Outpatient	3 DOA Oth	OF.	ing Home 5□ Res		er (Specify)	
g Physer this neral di	27. Menner of Death		28b. Time of Injury	28c. Injur Wor			how injury occur		- 0
ndin ath. r: Aft	1 Natural 5 Pending investigation	11/2/00	0830		Yes 2 No	Mater 1	chiele a	cude	nl
Divisio	3 Sulcide 6 Could not be determined	28e. Placa of Injury - At hor building, etc. (Specify)	ne, farm, street	t, factory, offica		28f. Location City or To	(Street and Numb	per or Rurel	Route Number,
Ce i i ed i e e e e			Stre	et		300 l	ouchun	le red	
Division of Vital Record To the Hospital or Attanding Physician: The law requir within 24 hours after death within 24 hours after death completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed		Ician: To the best of my know er: On the basis of examination end menner stated.							
To the comp	29b. Signature and title of certifier	10		29c. Licens	e number		29d. Date signe	,	
	16-14.1	Je mo		RES	5-000	>	Mouem	ler 7,	2000
	30. Name and address of person who con	mpieted cause of death (Item	23a) (Type, Pri	int)		llunare			
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure ,	1	1		-		
Registrar	NOV 0 8 200	1 peneva	19	Spark	1				



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State of Maryland / Department of Health and Mental Hygiene UU 37363

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** EVELYNE. BAILEY 5:15 PM 2000 Nov /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner HO WAKD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA If Under 24 Hrs. If Linder 8. Date of Birth (Month, Dey, Year) Aug 9, 19 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Funeral Deys 1 M 2 XF 89 Washington DC 578 16 2476 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at 1 Yes 2 Ho Director Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 United States 7970 Citadel Drive 21144 Nems 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: "natural", or by 3 S Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) se filed within 7 sel Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 8 permit. Pages 1 and 2 should be fit Department of Heelth and Mentel Hy Important: if Item 27 is marked ofth eny injury or other treumatic event, 2015. 18 Mother's Name (First Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Jane MacNicholas John Fersinger 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 7970 Citadel Drive Severn, Maryland 21144 Diane Gaynor/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☑Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Arlington Nat'l Cem. 11+29-2000 Arlington, VA MO1044 22. Name end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 21. Signeture of Funerel Service Licensee 0 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury attending physician and 68760 Physician/Medical thet initieted events resulting in death) Last Due to (or as a consequence of) Box P.O. | 23b. Did tobacco use contribute to the cause of death? been signed by the s should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Was an eutopsy 1 Yes 2 No 1 Yes 2 No after deeth.
Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Unpatient 2 □ ER/Outpatient 3 □ DOA 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end placa, and due to the ceuse(s) end menner steted. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Nov. 17, 2000 D36845 30. Name and address of person who completed cause of death (Item 23s) (Type, Print) MAI-CHI NGU YEN, M.D., FCCP 7350 MD 21041 Cotum grzce 32. Registrar's Signature Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month CLARK Nov. 5,2000 5:05 A.M. 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Larkin Chase Nursing Center Bowie Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 1, 1925 Birthplace (State or Foreign Country)
 Ohio 7. Age (In yrs. last birthdey) 1 M 2 F Months Yrs. 10b. County 10c. City. Town or Location 10d. Inside City Limits Prince Georges Bowie 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 3909 New Haven Court 20716 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Biack, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Nurse's Aid Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0. Johnson James A. Porter Haze1 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Paul Clark / spouse same as 10e 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State Data 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan CrematoryNov. 5,2000 Alexandria, Va. 4 ☐ Donation 5 ☐ Offer (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home Inc 21. Signature of Funeral Service Com 16000 Annapolis Rd., Bowie, Md. 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batweer Onset and Death Metastatic Lung Cancer pertensive Candio Vas Cular Disease Due to (or as a consequence of)

**Physician** /Medical Examiner

requires that the death certificate be executed

signed b

been si

certificate Physician:

this

Director: /

Hospital or Attending

after death.

To the Hospital within 24 hours a To the Funeral C

page

director,

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Completed

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Certification:

edical

Division of Vital Records. P.O. Box 68760.

pemit. Pages 1 and 2 sh Department of Health and Important: If hem 27 is m

Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last 90 for usa as

FAYE

10a. State

Md.

Directo

Funeral

by

5. Sociel Security Number

294-26-3368

10e. Street and Number

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

11. Marital Status

Usual Residence of Decedent

**Physician** 

/Medical

Examiner

**Funeral** 

Director

0.

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Ware autopsy tindings evailable prior to completion of cause of death?

1 ☐ Yes 2 No 26. Place of Death (Check only ona)

1 ☐ Yes 2 ☐ No

25. Was casa rafarred to medical 1□ Yes 2 No

5 Pending investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 ☐ Yes 2 ☐ No

Other: Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

6 Could not be 28a. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

27. Manner of Death

1 Naturat

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier Rakush arong MD

D20108

29d. Date signed (Month, Dey, Year) 15100

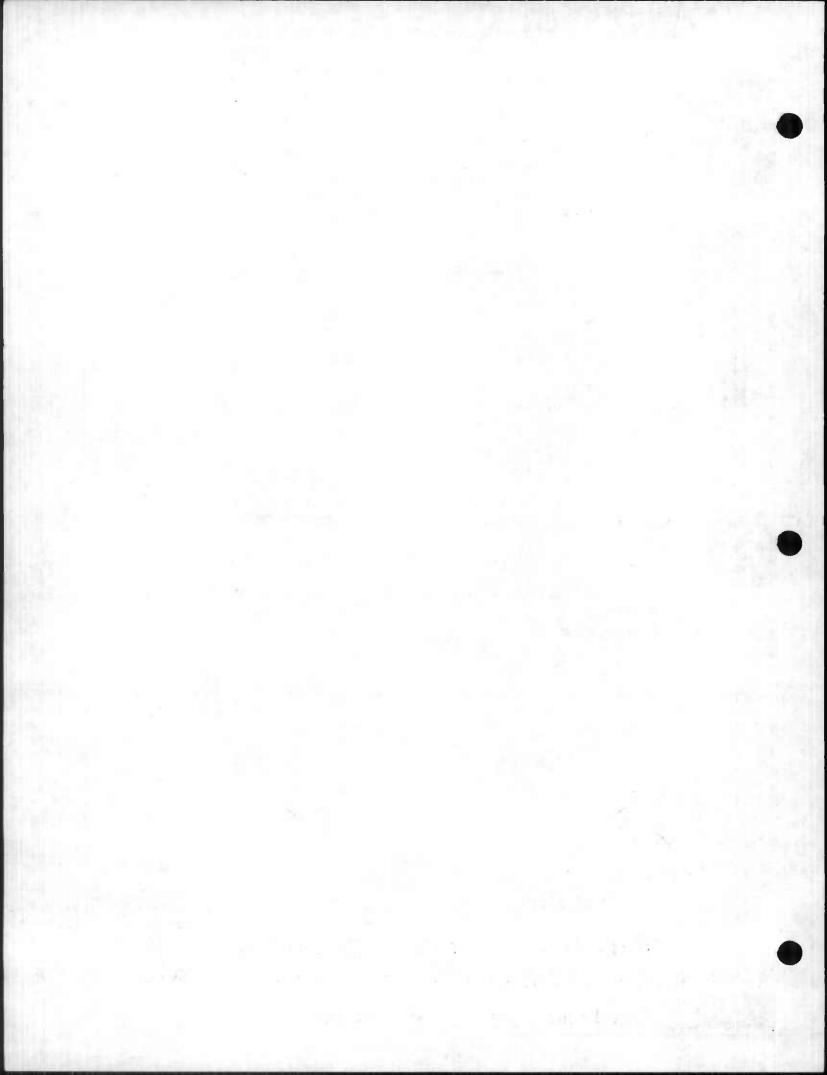
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAKESH ARORA, MD: 14300GALLANT FOX LANE, BOWIE
M020715

31. Date filed (Month, Dey, Year)

NOV 0 6 2000

32, Registrar's Signature

Registrar

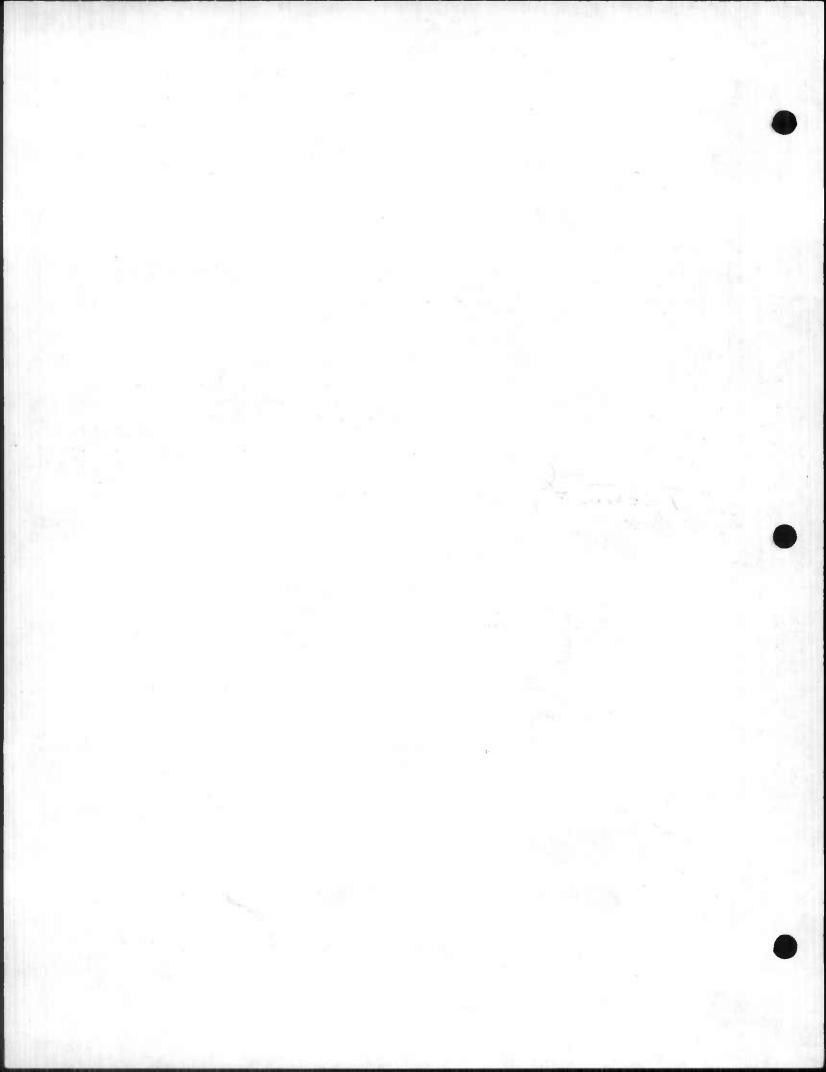


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State of Maryland / Department of Health and Mental Hygiene 00 37365

		Ce	rtificate of	Deam		Reg. No.	0,000			
Physicia	RACHIOLO NEXADE LAXEE				2. Dete of De Month Novemb		3. Time of Death 3:05 A.M			
/Medic Examin	er 4a Facility Name (If not institution, giva street and number)			4b. City, Town, or	Location of Deat	h 4c. County	of Death			
	10411 Harmony Rd.		If Under 1 Year	Myers vi			ederick			
Funeral Director	5. Social Security Number  220-28-8906  Usual Residence of Decedent	s. last birthday) Yrs.	Months Days		s. 8. Date of Bin. (Month, D.) Sept. 1	6,1933	9. Birthplaca (State or Forei Country) Maryland			
Jand Jand		City, Town or Lo	ocation				10d. Inside City Limit			
death with the Maryland ms 23a or 28a-f show mant be notified at	Md. Frederick	Myer	sville				1 □ Yes 2 🗹 N			
or 28	10a. Street and Number		10f. Zip Code			10g. Citizen of	What Country?			
ath w	10411 Harmony Rd.			21773			I.S.A			
	Md. Frederick  10a. Street and Number  10411 Harmony Rd.  11. Marital Status  1 Never Marriad Married  3 Widowed 4 Divorced  10a. Street and Number  12. Was Decedent Ever in Armed Forcas?  13. Yes 2 No  14. Yes, Give  Year or Datas 5 3 - 5		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 No	Hispanic Origin? ( ban, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Specify	e - Amarican Indian, ck, White, etc.			
2 hour	15. Decedent's Education		dent's Usual Occu	pation		16b. Kind of B	usiness/industry			
filed within 72 hours after Hygiene. ther than "natural", or fe ent, the Medical Examin	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)		kind of work done DO NOT use retire INE Oper	pation during most of wi ad) ator	orking	Exca	vating			
8 2 2 3	17. Father's Name (First, Middla, Last) Grayson Ray Cline				ame (First, Middle dred Luc					
od 2 sho	19a. Informant's Name/Relationship (Type, Print) Shoron D. Cline (Wife)			Rd. Mye						
perunit Pages 1 a Department of Hea mportant. If item iny injury or offisi	1 Burial 2 Oceanation 3 Demove from State	cemetery, cree	esition (Name of matory or other pla g Cremat		Nov. 8 2000		City or Town, State			
Semil. Pa Separmor reportant my injury alsa.	21. Signature of Funeral Service Licenses		2. Nama and Addr		12525	Bradhur	, Aue			
SEE SE	Kemis X. Nava	7 D	avis Fun	eral Hom	e Smiths	burg. Md.	21783			
certificate be executed making physician and use as the buriel-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	(or es a consec	enca quence of): DISCASE		V17(					
for atte		esulting in the u	nderlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to the cause of deat			
thet the page of t	E Hyponar Remia				12	Yes 2□ No	3 Probably 4 Unkno			
ox Attending Physician: The law requires that the death after deeth. Physician: Spirector: After this centificate has been signed by the atter lin by the funeral director, page 2 should be detached for utility.	Part II. Other significant conditions contributing to death but not re					an autopsy ormed?	24b. Were autopsy findings available prior to completion of causa of death?			
iclen: The lav certificate has irector, page 2	E.				10	Yes 21 No	1 Yes 2 No			
fan: Trifica	25. Was case referred to medical examiner?			26. Place of De	eath (Check only	one)				
hyalo his ce al dire	1 Yes 2 No Hospital: 1 Inpatient 2		N 3LI DOA		Home 52 Res					
To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	27. Manner of Death 1 Netural 5 Pending investigation 2 Accident 5 Could not be determined 28e. Plece of Injury (Month, Day Year) 28e. Plece of Injury (Month, Day Year) 28e. Plece of Injury - At building, etc. (Special Country)	28b. Time of Injury	M 1	Yes 2□No		how injury occur				
oftal or Attendius after deeth.										
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.									
withir To th	29b. Signature and title of certifier	//	29c. Licen	se number			d (Month, Day, Year)			
	Curene B. Casagran	de	D4	0307		11-10	-00			
	30. Neme and address of person who completed cause of death (lite			1		01700				
	Eugene B. Casagrande M.D. 1564				rick, Md.	21/02				
Stat Registra	MIN A THINK	15	poor	KS						

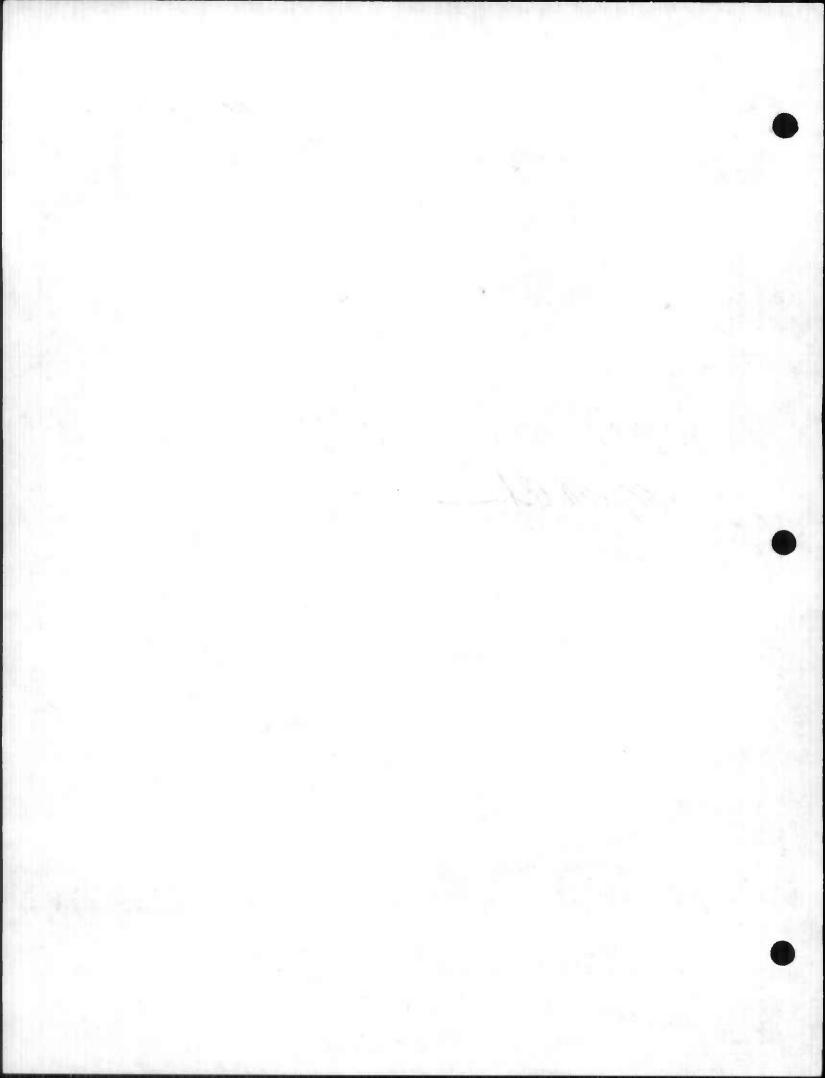
Registrar



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State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 3 6 6

					Cei	rtificate	of D	eath		Reg. No		
		1. Decedent's Name (First, Mic	idle, Last)						2. Dete of		Mana	3. Time of Death
I Dec	Physician (Madiaa)	Daisy Viola C	lipp						Novem	ber 11		0345
	/Medical Examiner	4a Facility Name (If not institut		er)			4b	. City, Town,	or Location of De	eath 4c	. County of Death	
	2,000	Washington Co	unty Hospita	al			H	lagerst	town	W	ashingto	on
	Funeral	5. Social Security Number		Age (In yrs. la	st birthday)	if Under 1	Year	If Under 24 H	irs. 8. Dete of	Birth Day, Year)	9. Birth	place (State or Foreign
я.	Director	213-24-9329 Usual Residence of Decedent	1□ M 2 <b>/8</b> F	77	Yrs.	MONGIS	Jays	110013	Feb.6		West	Virginia
	M M	10e. State 10b. Cour	nty	10c. City,	Town or Lo	cation		5 5 5 6				10d. Inside City Limits
	Mark at	Maryland Wash	ington	Hage	rstow	n						1 ☐ Yes 2 X No
	with the Marylar a or 28e-f show Lbe notified at	10e. Street and Number	N - SP-84			10f. Zip Co	ode			10g. Cit	izen of What Cou	intry?
	fi will	17408 Virginia	Avenue			217	40			US	Α	
	ther death with the Maryla ritems 23a or 28a-f sho infer matt be notified at Funeral Director	11. Merital Status	12. Was Decede Armed Force	ent Ever in U,S	. 13.	Was Deceden	nt of His	panic Origin? Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	14. Race - Amer Black, White	
Baltimore, Maryland 21215-0020	by F	3 ₩ Widowed 4 Divorc	arried 1 Yes 2	No		1 □ Yes 2 🎾		Specify:			Specify: Whi	
9	be flad within 72 ha tal Hygiene. d other than "natur event, the Medical. Be Completed	15. Deced	ent's Educetion		16a. Dece	dent's Usual C	Occupati	ion	undring	16b. K	ind of Business/li	ndustry
2	Med Med	Elementary/Secondary (0-12	hest grade completed) College (1-4	or 5+)	life.	kind of work of DO NOT use	retired)	iring most or i	WOIKING			
2	w but and	6			House	wife					lome	
pu	ahould be filed nd Mental Hyg marked other matic event, I	17. Fether's Name (First, Middle					1		Name (First, Mid			
yla	marke marke	Lonnie Fulton	Fiddler					VIOIA	Mamie J	onnsc	) [1	
ar	and and sum	19a. Informant's Name/Relation									or Town, State, Z	
2	and n 27	Charles Clipp,	Sr.			2 Blai		Valley			Spring, MI	
ore	I the H	20a. Method of Disposition 1    Burial 2 □ Crematio	n 3 □Removal from Str	cor	nea of Dispo metery, crer	sition (Name matory or other	of er place)	)	Date		ocation - City or T	
E	Pag ment ant:	4 Donation 5 Other		Rose	Hill	Cemet	ery	Nov.1	4,2000	Hag	gerstown	,Maryland
Ball	permit. Pages 1 and 2 ah Department of Health and Important: if them 27 is me any injury or other traum 2008.	21. Signature of Funeral Servi	10/10			2. Name and / sborne			Home 42	25 S.C	Conococh	eague St. D 21795
		23a. Part Librar the disease, shock or heart failure. L	or complications that cau	sed the death.	Do not ent	er the mode of	of dying,	such as card			ispor 1, Mi	Approximate
	Physician	shock or heart failure. L	ist only one cause on eac	tine.								Onset end Death
	/Medical	Immediete Cause (Final		11mon								I weeky
	Examiner	disease or condition resulting in death)	a	Dun to /or	as a consec	tuonoo of):					1	x many
	<u> </u>		- FNd	ctn	as a consoc	( · / .	0	10/0	_			
	executed in and hal-transit	Sequentially list conditions	b. PNA	Due to (or	s a consec	uence of	9	1100	-		1	
ó	exec manual rial-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		7	,						1	
68760,	eath certificate be executed attending physician and for use as the bunal-transit clary.	Cause (Disease or Injury that initieted events	С.	Due to (or a	as a consec	uence of):						
89	ng ph ng ph as th	resulting In death) Last									1	
Box	endir r use		d									
	deat de att ed fo	Part II. Other significant cond	Itions contributing to deat	h but not result	ting in the u	nderlying cau	se giver	n in Part I.	23b. D	Oid tobacco	uss contributs	to the cause of death
P.0	that the death ed by the atter detached for u	riansel	1 - 1 - 1 -	1 .	n.	1.		Dian.	1	□ Yes :	2□ No 3□ Pr	obably 40 Unknow
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Vital Records,	w requires that the death cert been signed by the attendin should be detached for use lieted by Physician/N	Lors 10000	Calle	tructue ro, t.c	00	10, 0.	100.		24a. W	vas an auto	6	Were eutopsy findings waitable prior to
S	as be	N Jean G	an wi	1 - pric	X	5/	114	1	- 1		0	completion of cause of deeth?
Records,	ician: The lav certificate has rector, page 2 Be Como	Hime fores							1	☐ Yes 2	No 1	Yes 2 No
Vital R	an: rtifica stor, s	25. Was case referred to medi	cal	,				26. Place of i	Death (Check or	nly one)		
> >	Physician: this certific ral director,	examiner?	Hospital:	atient 2 E	R/Outpatier	nt 3 DOA	Other	4 □ Nursin	g Home 5□R	lesidenca	6 ☐Other (Spec	oify)
1 of	er this neral di	27. Manner of Death	28a. Date of	tnjury Day Year)	28b. Time o	f 28c	. Injury	at	28d. Descri	be how inju	iry occurred	
Ö	Attending Process.  Attending Process.  Attending to the funeral or the funeral o	1 @Naturel 5 Pen- 2 Accident inve	stigation (World)	Day roan	intery	М		es 2 No				
Division	Attend ar death ector: by the	3 Suicide 6 Cou 4 Homicide dete	rmined 200. Placa of	Injury - At hon , etc. (Specify)	ne, farm, str	eet, factory, o	office		28f. Locatio	n (Street a	nd Number or Ru	ral Route Number,
	s after selection of in	/	building	, etc. (Opecny)					0.0,0		-,	
	To the Noepital or Attending Physician: The law requires that the death or within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for us Wedical Certification: To Be Completed by Physician's	29a. Certifier 1 Certific (Check only 2 Medic	ying Physician: To the be al Examiner: On the basi and manne	is of examinetic	ledge, deatl on and/or in	n occurred at vestigation, In	the time my opi	e, dete and plantinion, deeth o	ace, end due to ccurred at the tir	the cause(s	s) end menner as d plece, and due	stated. to the cause(s)
	within 2 To the comple	29b. Signature and title of certi				29c. L	License	number		29d. Da	ate signed (Monti	n, Day, Year)
	- > - 0	Ille Pozn	Mo			D	22	313			11-	11-00
		30. Name and address of person	on who completed cause	of death (Item 1	23a) (Type	Print)	51 5	inc+ ^-	tiotam	С+ Н	ageretou	n MD 21740
		Eci nom 4	· lancing		100	174	H	OSI MI	ac all	31 i II	ageratow	n,MD 21740
	State	31. Dete filed (Month, Day, Yea		istrar's Signatu	respon	Ks	- / -	3,777				
	State Registrar	NOV 1 3 2000	pere	1	10	-						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2, Euphamie Helen Cronmiller 2000 12:50 AM /Medical November 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home Denton

If Under 24 Hrs. Caroline If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 X F YES **Director** 214-28-4722 July 11,1903 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or frama 23a or 28a-f ahow 1 ☐ Yes 2 No Maryland Caroline Ridgely 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Dir death v 23940 Carrlyn 21660 Funeral Drive USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status be filed within 72 hours after dital Hygiene.
dictions in atural, or flem of other than "natural, or flem event, to be distinct. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse government permit. Peges 1 and 2 should be flie Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event bace. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Jesse Stoner Maggie Boyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Sparks 23940 Carrlyn Drive 21660 daughter Ridgely, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place) Nov 4 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery 2000 Laurel, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle - Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner physician end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): for use as P.O. sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Records, ģ 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed cartificate has 1 Yes 2010 I ☐ Yes 2 ☐ No Division of Vitai or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To After this funerel 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1- Netural 5 Pending investigation To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Janes

31. Date liled (Month. Day, Year)

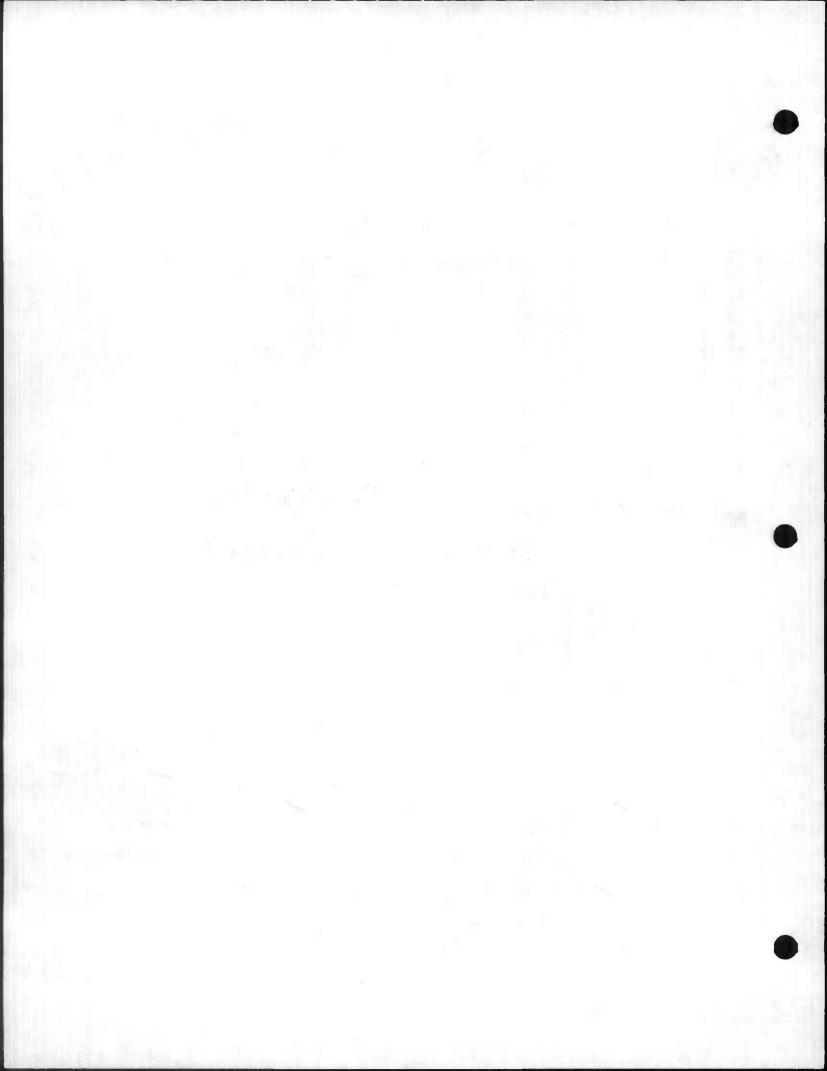
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32. Registrar's Signature

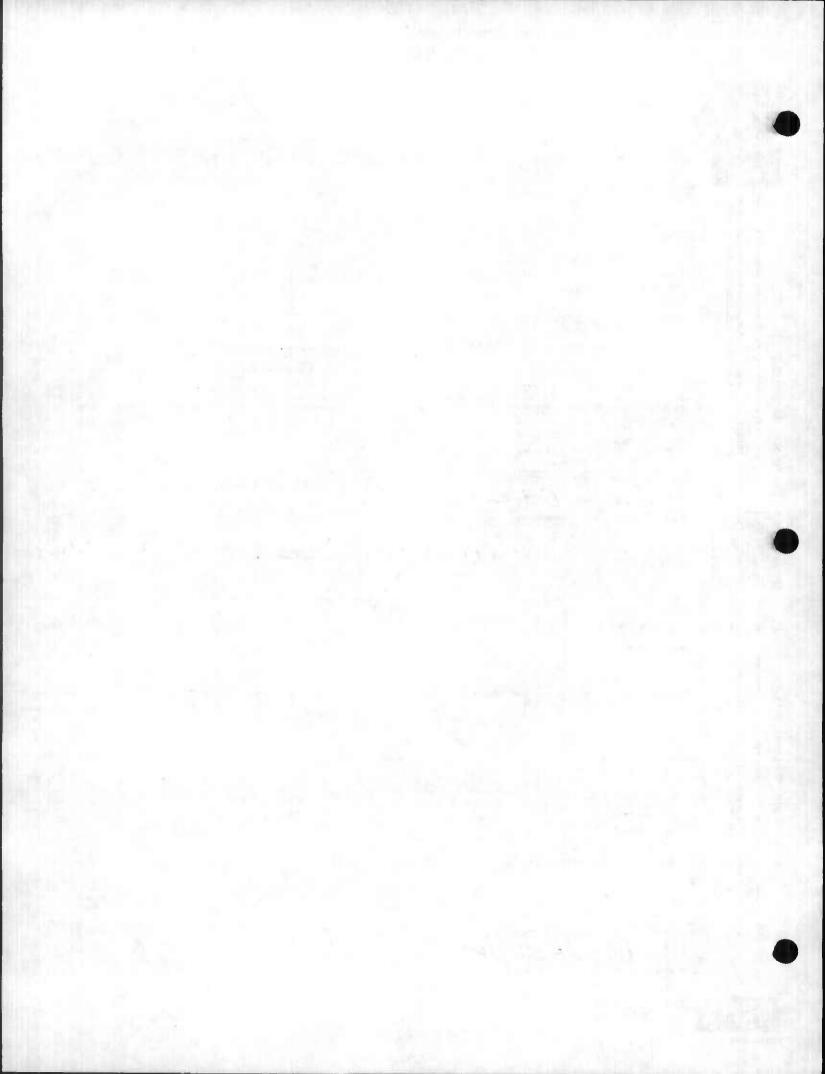
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Physician /Medical Examiner  Funeral Director	JOHN JOSEPH COL     Facility Name (first, Middle, Las     JOHN JOSEPH COL     4a Facility Name (ff not institution, give     24362 WIDGEON PL     5. Social Security Number     253-36-7194  Usual Rasidenca of Decedant     10b. County	LINS, JR. e street and number) ACE UNIT #3	s, last birthday) Yrs.		er 1 Yaar		MM, or Local		R 5 4c. County of		3. Time of Death 11:25 P
/Medical Examiner Funeral Director	4a Facility Name (If not institution, give 24362 WIDGEON PL 5. Social Security Number 6. Si 253-36-7194 Usual Rasidenca of Decedant	ACE UNIT #3				ST.M	m, or Loca	OVEMBE ation of Death	R 5 4c. County of	2000 of Death	11:25 P
Examiner  Funeral Director	4a Facility Name (If not institution, give 24362 WIDGEON PL 5. Social Security Number 6. Si 253-36-7194 Usual Rasidenca of Decedant	ACE UNIT #3				ST.M	ICHAE	LS	4c. County of	of Death	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month CURRAN 15:02 IIMOTHY November 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death HOSPITAZ JOHNS HOPKIMS Baltimore If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 X M 2 F 214-62-1352 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9415 Decatur Road 20723 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1t. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Machine Elementery/Secondary (0-12) College (1-4or 5+) Manufacturing Company Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Joseph M. Curran, Jr. Agnes G. Whitehead 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia E. Curran spouse 9415 Decatur Road, Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) Metro Crematory, Inc. 11/20/00 Catonsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. utt 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) . End Stage Liver Disease Due to (o) es a consequença of) Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy 1 PYes 2 □ No 1 ☐ Yes 2 ☑ No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitat: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death

**Physician** /Medical Examiner

USB

page 2 should be

Medicai Certification: To

The law requires that the death certificate be executed

Hospital or Attending Physician:

s after death.

within 24 hours To the Funeral

completely

P.O. Box 68760,

Vitai Records,

Division of

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

**Funeral** 

Director

the Medical Examiner

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Pages 1 and 2 at ment of Health an Department of Health a Important: if Item 27 is any injury or other tras 20058.

72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events resulting in death) Last Be Completed by

1 Naturet

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Pending Investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and memer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 Could not be determined

29c. License number Res-000 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

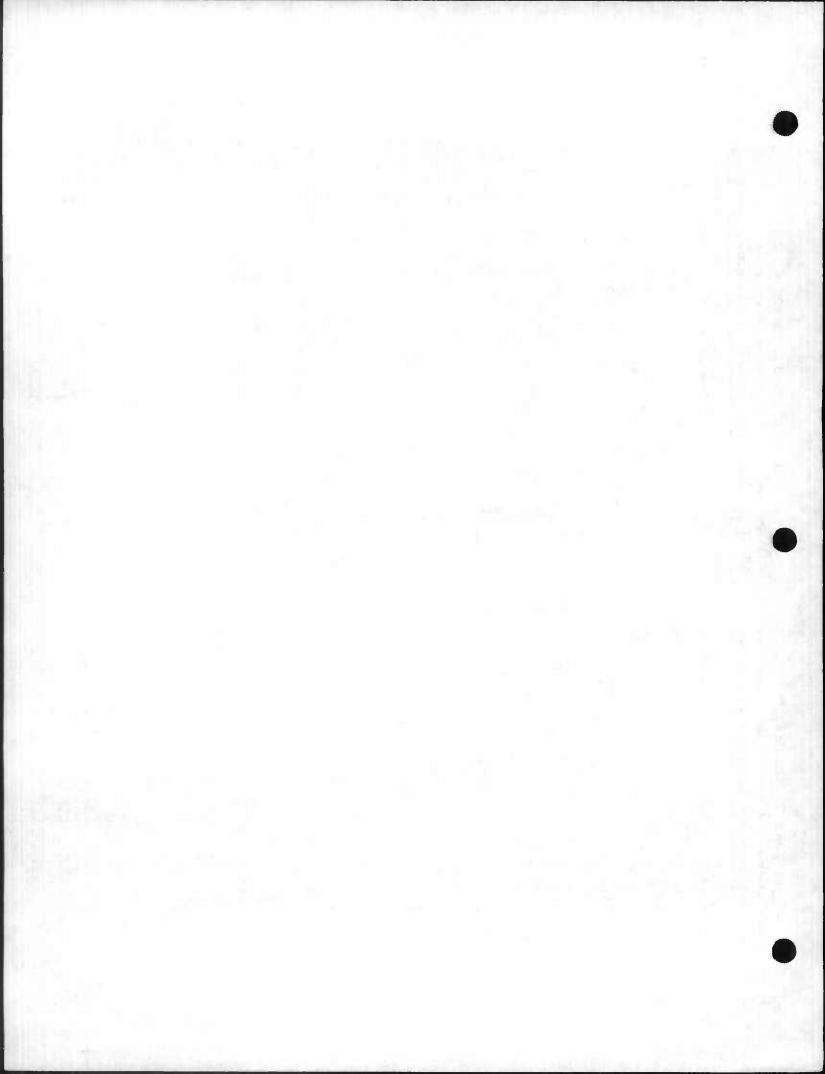
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301 North caroline street Baltimure maryland Salomeh Keyhani

State Registrar

31. Date filed (Month, Day, Year) NOV 2

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Veal William J. Clarke, IL 8:15am NOU 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Head Center alisbun Deers Willomico If Under 1 Year | If Under 24 Hrs. 8. Days of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1**X** M 2□ F Months Days 221-14-7930 Yrs. 79 5/9/1921 MD **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Worcester Snow Hill 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6032 Whiton RD 21863 USA 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Statue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WWII 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/ Operator Construction Co. 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surname) John James Clarke Jenny Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Wilda Clarke/ Wife 6032 Whiton RD Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other presentery 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from Stata Whatcoat United Methodist 11/11/00 Snow Hill, MD 4 Donation 5 Other (Specify) e at Banera Service Lices 22. Nama and Address of Facility Burbage Funeral Home 208 W. Federal St. Snow Hill, MD or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, unt only one cause on each line. Approximata Intervat Between Onsat and Death heart failure SEULVER Immediate Cause (Final disease or condition resulting in death) month arten 20 YEAVS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated obstruction pulmonary diseus, Chronic Venas Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Diabets mellitus 1 Yes 2 No 3 Probably 4 Unknown Hypothyroidism, History of repair & abdominal 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? MRSA and 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical axaminer? 26. Place of Death (Check only ona) Hospital: 1 Hopatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Natural

Physician /Medical Examiner

Department or important: If any injury or page.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Nerns 23s or

"natural", or

Peges 1 and 2 should be filed within ant of Health and Mentel Hyglene.
Int: If Item 27 is marked other than "!

72 hours efter

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

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Division

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Physician/Medical Examiner Completed To Be Certification: After or Attending ie Hospital or Attending n. 24 hours eiter deeth. ie Funerel Director: Aft pletely filled in by the fur To the Hosp within 24 hor To the Fune completely fi

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Registrar

2 ☐ Accident

3 ☐ Suicide

29a. Certifie

4 Homicide

(Check only one)

29b. Signature and titla of certified

MO

29c. License number D16003

1 Yas 2 No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

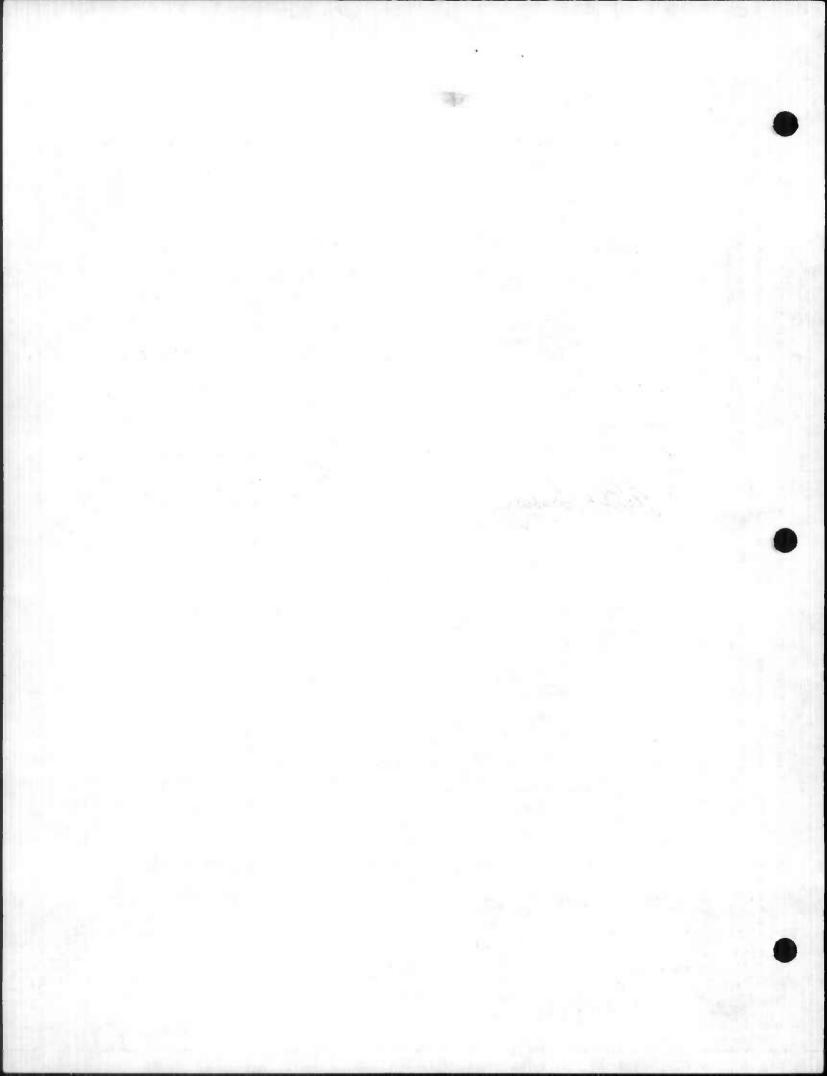
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BOX 2018 Salisbury 31. Data filed (Month, Day, Year)

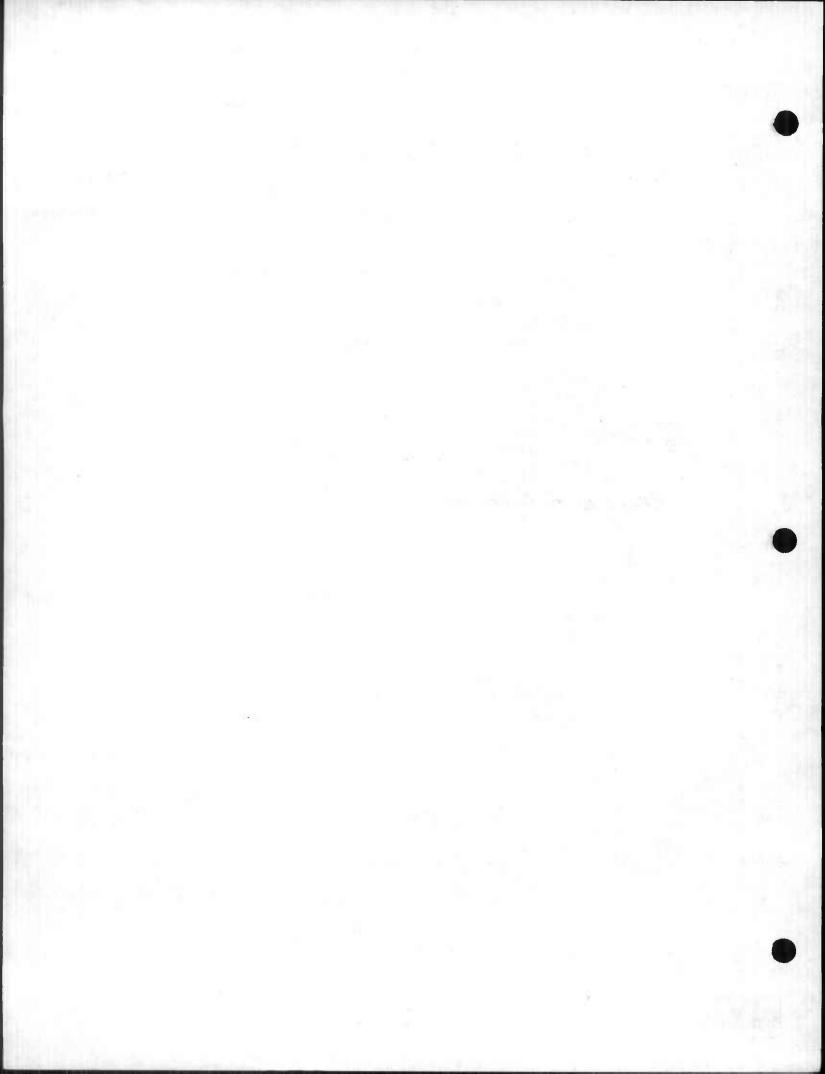
21802 - 2018 Inja J. Hwang, 32. Registrar's Signature Beneva

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)



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	1. Decedent's Nama (	First, Middla, Last)						2. Data of De			3. Tima of Death	
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rai	5. Social Security Num	1 1	IM SKIE	(In yrs. last birth	Months	Days	If Undar 24 Hrs. Hours Min.	8. Data of Bir (Month, Da	th y, Year)	9. Birthp Coun	lace (Stata or Foreign itry)	
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10	19a. informant's Nam		ma Print)	10h	Mailing Address	e (Street	and Number or Rur		er City or Town	Steta Zin	(Coda)	
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	· Chan	leas L	Belen	w	6633	old A	Alexandria	a Ferry	Road Cl		n, MD 20735	
	23a. Part1. Enter the shock, or heart f	disaasa, or compli	cations that caused the	ha daath. Do no	ot enter tha mo	da of dyi	ng, such as cardiac	or raspiratory a	rrast,		Approximata Intarval Batween	
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Examiner			). (M)	ue to (or as a co	200	no	II.	_				
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lan			J.									
Physician/M	Part II. Other eignifica	int conditions con	tributing to death but	not rasulting in	tha underlying	cause gh	ren in Part I.				o the cause of death?	
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d by	- A	1	PI	1	10	2	ACCULATION.	24a. Waş	an autopsy		are autopsy findings	
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ino ino	27. Manner of Death 1920 Natural	5 ☐ Pending	28a Date of Injury (Month, Day		jury	28c. Inju Wo		28d. Describe	how injury occur	red		
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Ö	29a, Cartifiar	Cartifulna Dhu	elcian: To the best of	my knowledge	death occurre	d at the ti	me dete and place	and due to the	ceuse(s) and m	anner as e	stated.	j
edical			ner: On the basis of a and mannar state	xamination and								
×	29b. Signatura and titl	a of cartifier	200	7	2	9c. Licans	sa number	-6	29d. Data signe	d (Month,	Dey, Year)	
	Man	-6	Lia	ce /	n	R	1225	/	no	3	2000	
	30. Nama and address	s of person who co	impiated causa of de	ath (Item 23a) (1	Гуре, Print)		V 7	1		-/		
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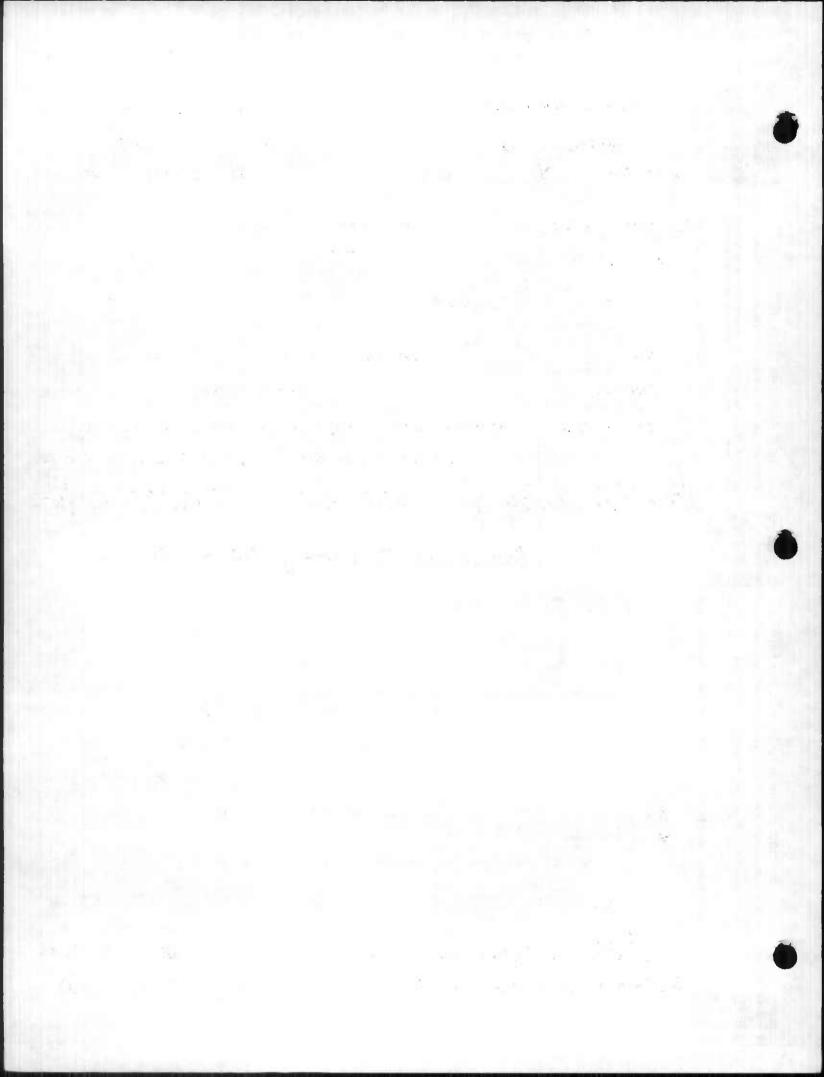


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 1. Decedent's Name /First. Middle. Last. 3. Time of Death Month **Physician** LEON SHERMAN DICK NOV. 12 2000 5 AM /Medical Hagerstown
Hunder 24 Hrs. 8. Dete of Birth
Month, Day, Year)
Min. 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27 Wayside Avenue Washington If Under 1 Year 7. Aga (In yrs. last birthday) 5. Social Security Numbar Birthplace (State or Foreign Country) **Funeral** M 20 F 69 Months Days Yrs. 220-26-6047 Maryland Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at TX Yas 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 27 Wayside Avenue death Funeral 12. Was Decedant Evar in U,S. Armed Forces?

12 Yes 2 □ No If Yes, Giva Year or Dates:1952-54 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Raca - American Indian Black, White, etc. hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: Specify:White by 3 ☐ Widowed 4 ♣ Divorced Completed be filed within 72 ho la! Hygiena. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) driver 10 service station 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fill h and Mental H Jacob S. Dick Mary B. Bitner 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Numbar, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
any injury or other treu Daughter 14778 Ridge Rd., Waynesboro, Pa. 17268 Leann S. Dick 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Ocremation 3 Ramoval from State Smithsburg Crematory 11/14/00 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical VAJulen Examiner Due to (or as a consequence of): Examine physician end the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. been signed by should be detact 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed hes 1 Yes 2 No Division of Vital 25. Was cese referred to medical examiner? Be 28. Place of Death (Check only one) 1 Yes 2 No Hospital: 5 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funarai 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: Aftar Natural 2 Accident 5 Pending or Attending after death. Director: After 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner statad. 29b. Signatura 29c. Licansa number 29d. Date signed (Month, Day, Year) Myedred & Kan 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) OCME 218 ARTHUR H. HORN VIRGINA 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2000 NOV 1 5 Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UU 37374 Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Dey 11 Month **Physician** 0435 November Marguerite Ann Doleman /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. Montha Deys Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 M 25F Yrs. **Director** PA 215 08 1161 Usuel Residence of Decedent 11/29/20 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County must be notified at 1 ☐ Yes 2 ☐ No Directo Hagerstown MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 540 N. Locust Street 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 1 Yea 2 No If Yes, Give A Year or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) s 1 and 2 should be to thesith and Mental H tem 27 is marked off Esther Pollard Henry J. Kelsh and la 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) -epartment of Health at important: if Nem 27 is n any Injury or oth 2008. 20b. Place of Disposition (Name of cametery, cremetory or other place)

537 N. Locust St., Hagerstown, MD 21740

Date 20c. Location - City or Town, Stele Rosemary Lucas-daugther 20a. Method of Disposition 1 Gurial 2 Cremetion 3 Removel from State
4 Donation 5 Other (Specify) Rose Hill Cemetery 11/14/00 Hagerstown, MD. 22. Neme end Address of Facility 21. Signature of Funeral Service Licerado Watson Funeral Home 21 W. Bethel Box 856 Hagerstown, MD21740

23a. Pertl. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Heart Farlun Consentin 2 hours Examiner Due to (or es e consequenca of): Examine 2 was Acute Myo andid Injuct. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of): Dirun 3 Antero relection Cardinaralan Physician/Medical Due to (or as e consequenca of): Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert it. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Likelihown Dichte mellites Parcretation þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate hes page 1 Yes 2 ANO 1 ☐ Yes 2 ☐ No Vital Be 25. Wes case referred to medicat 26. Piece of Death (Check only one) Hospitel: 1 thpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division or Attending 5 Pending 1 Naturel after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Confifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) end menner stated. 29e. Certifier edicai 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number NOV 11 2000 -conamo 218019 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 334 CASANT DATTA MD MILL ST MAGERSTOWN, MD 21748 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State NOV 1 3 2000

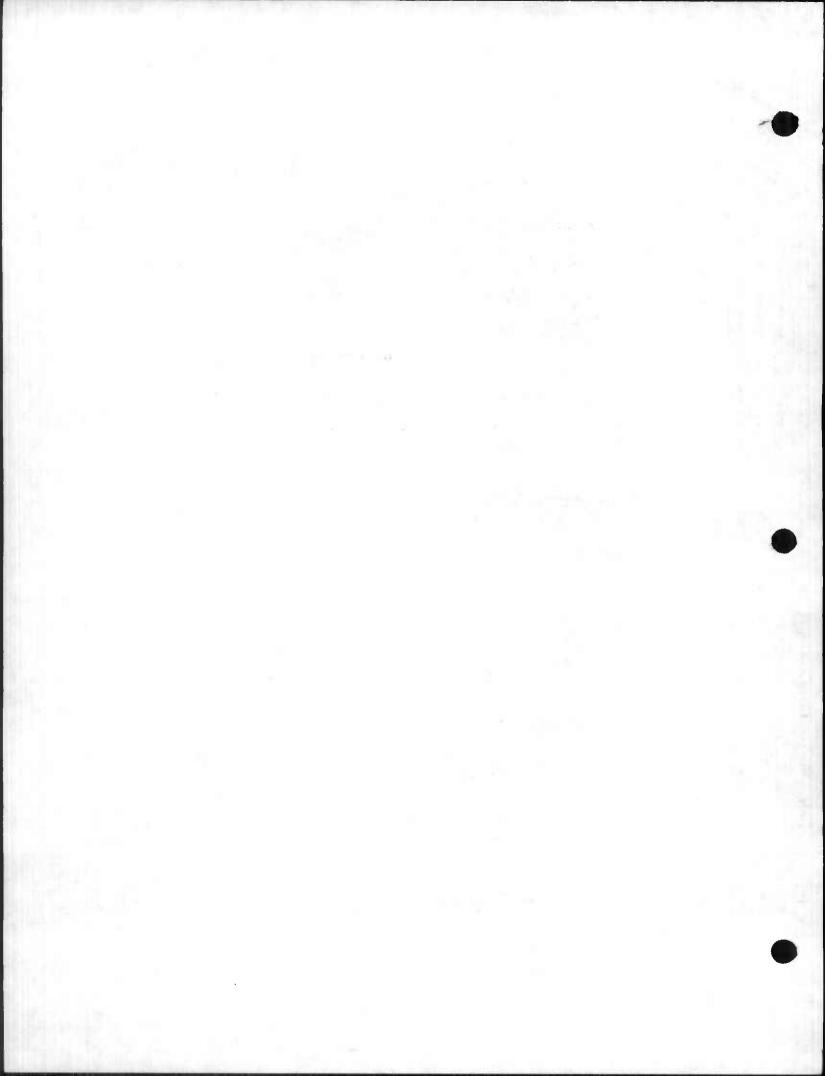
**DHMH 16 Rev 6/95** 

Registrar

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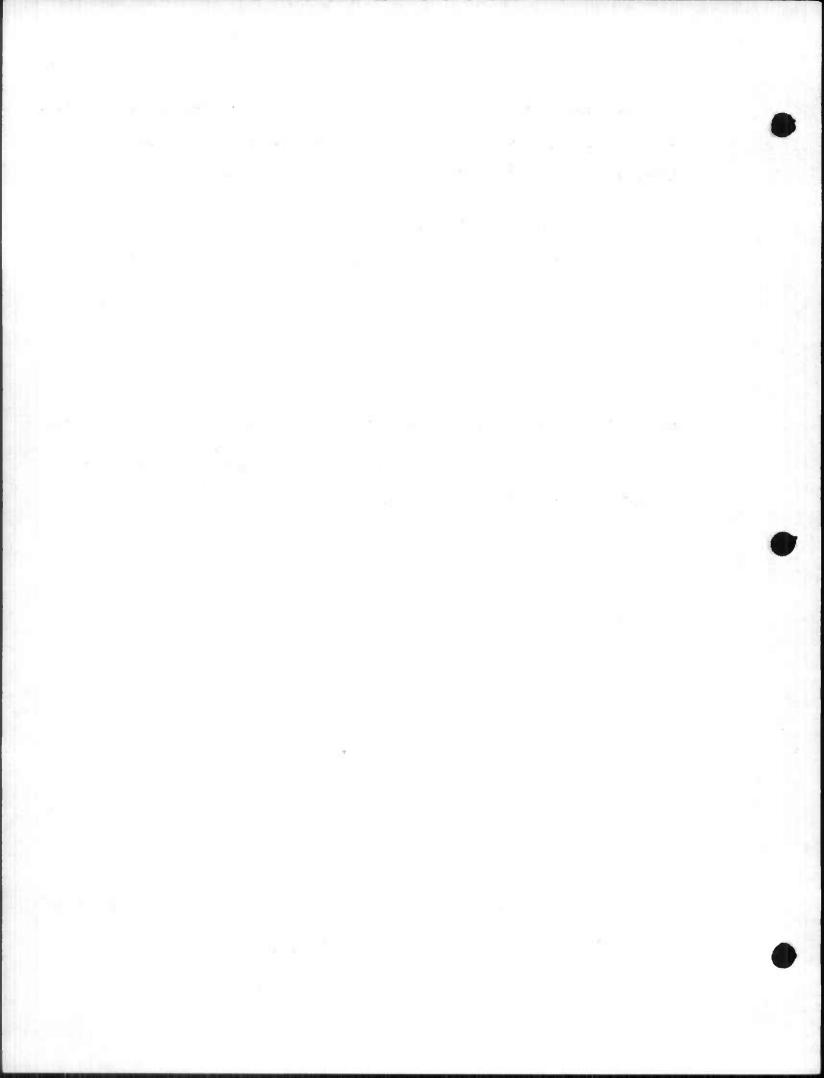
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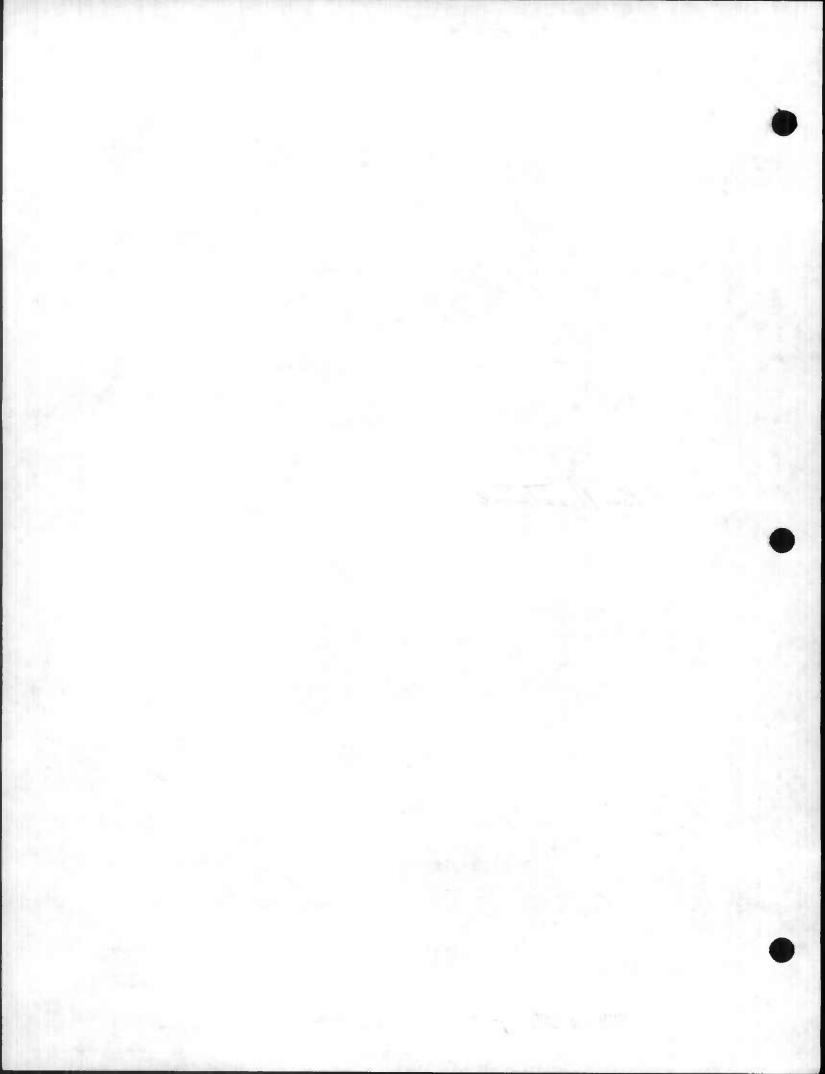
		1 Decederate Name (First Middle Leaving)				tificate of		Mental Hy	Reg. No.		1313
Physici	an	Decedant's Name (First, Middla, Last						2. Data of D. Month	Qay	00 Year	3. Tima of Death
/Medic		Jeanette Virginia						Novemb		00	8:10a.m.
Examir	er	4a. Facility Nema (If not institution, give	A Water Action					or Location of Dee	th 4c. Count	y ot Death	
		Caroline Nursing	Home, Inc			D	enton,M	aryland	Card	oline	
Funeral		Social Security Number     6. Sa		ge (In yrs. last bi		If Undar 1 Yaar Months Deys	If Under 24 H		rth	9. Birthp	place (Stata or Foraig
Director		220-28-4/84	]M 2XF	82	Yrs.	Boyo		Aug 3	1918		land
P.		Usual Residence of Decedant		T							
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vith the Maryle or 28s-f show	ire	10e. Street end Number				10f. Zip Coda			10g. Citizan of	What Cour	ntry?
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deeth with the Marylend	Funeral Director	11. Maritel Status	12. Wes Decedent Armed Forces	Ever In U,S.	13. V		ispenic Orlgin?	(Specify Yas or Norto Rican, etc.)		ce - Amaric	
or he	by Fur	1 ☐ Navar Merried 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces  1 ☐ Yas 2 X If Yas, Giva Year or Detas:			Yas, specify Cube  ☐ Yas 2 No	Specify:	erto Rican, etc.)	Speci	ick, White, fy: wh:	etc. ite
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should be filed within and Mentel Hygiene. merked other than ametic avent, the Ma	Be						TO. INIO(IIIOI 3 I	atina (i ii si, isiioole	i, marcan cuma	maj	
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1 and 2 Health em 27		Bernice Fay Conley	daught			Bee Tre		Henders			21640
ges 1 and 2 should be filed within to the Health and Mentel hygiene. If item 27 is marked other than or other traumatic avant, trains		20a. Mathod of Disposition 1 M Burial 2 ☐ Cremetion 3 ☐ F	Samoual from State	20b. Place of cemete	of Dispos ory, cram	sition (Nema of natory or other piec	ca)	Nov 4	20c, Location	- City or To	own, Stata
Pages nent of I int: if its iry or o		4 Donetion 5 Other (Specify)			shor	o Cemete	rv	2000	Greens	horo.	Maryland
permit. Pages 1 and 2: Depertment of Health a Important: If Item 27 is any injury or other trace once.		21. Signature of Funaral Sarvice Licens	aa	020011	-	Name and Addra		12000	orcens	,	naryrand
Depermine Depermine any ir ponce.		11/1/	60	,				bein Fun			
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Examiner		resulting in death)		Due to (or as a		uence of):					LEBIZ
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Attending Ph or deeth. ector: After th by the funeral		27. Mannar ot Death  1. Naturel 5 Pending investigation	28a. Date of Inju (Month, Da	ay Year) 28b.	Tima of Injury	28c. Injur Wor M 1 🗆			how injury occu		
To the Hospital or Attanding Physician: within 24 hours efter death. To the Funeral Director, After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be datermined	28a. Place of Inbuilding, at	jury - At homa, fo c. <i>(Specify)</i>	arm, stre	eat, factory, office			(Street and Num wn, Stata)	ber or Rura	Il Route Number,
Hospit     24 hour     Funeraletely fills	edicai	29a. Certifler (Check only one) 12 Certifying Physical Example (Check only one)	pician: To the best ner: On the basis o end menner st	t axamination ar	a, daath nd/or inv	occurred at tha tin astigation, in my o	ne, deta and pia pinion, death oc	ce, and dua to the curred et tha time	cause(s) end m	annar as s	teted. the cause(s)
Nithir To th	M	29b. Signetura end titla of certifier	, \			29c. Licens	e number		29d. Dete sign	ed (Month,	Day, Year)
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		30. Nama and address of person who co									
			Market			Marylan	d 2162	9			
State		31. Data tiled (Month, Day, Year) NOV = 3 2000		rade Signatura	1.	PRICES					
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 3 7 6

	1. Decedent's Name (First	, Middle, Last	)	,		ertifica			1:	2. Dete of De	Reg. No.		3. Time of	f Death
Physician			ELSTER		DYSAI	RT				Month VEMBE	Day	Year 2000		
/Medical Examiner	4a Facility Name (If not in					-		4b. City, Town			7	nty of Death	h	
	Saint Jos	eph M	ledical	Cent	: er				son			Balt	imore	
Funeral Director	5. Social Security Number 4 0 4 - 2 0 - 1 0 8	1 10	x	Age (In yrs.	last birthda 1 Yrs.	y) If Unde Months	Days		Hrs. 1 Min.	8. Dete of Bir (Month, Da 1 / 1 2 / 1	th ly, <i>Year)</i> 1909		hplace (State of untry) ITUCKY	
t u	Usual Residence of Deced 10a. State 10b.	County		10c. Ci	ty, Town or	Location							10d. Inside C	ity Limits
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be notified be notified Director	10e. Street and Number					10f. Zi	Code				10g. Citizen	of What Co	untry?	
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tr, or thems 23/ Examiner must by Funeral	11. Maritel Stetus  1 □ Never Married 2  3 ☑ Widowed 4 □ D		12. Was Deceder Armed Force 1 Yes 2 Hr Yes, Give Year or Dates	s? D No	J,S. 10			lispanic Origin an, Mexicen, F Specify:	? (Spec Puerto R	city Yes or No lican, etc.)		Black, White	rican Indian, e, etc.	
	15. D	ecedent's Edu	cetion		16a. Dec	cedent's Usu	al Occup	pation	d a considerin		16b. Kind o			1
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Be well	17. Father's Name (First, I	Middle, Last) PHILLI	מי	ROWI	7					(First, Middle	, Maiden Sun			
To To	t9a. Informant's Name/Re			KOWI	1	iling Addres	s /Straal	and Number of	NN	Route Numb	er City or To		KNOWN	
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ysician ledical	23a. Part1. Enterthe dise shock, or heart failur Immediate Cause (Final disease or condition	ase or comp e. List only o	lications that cause ne cause on each		th. Do not e	enter the mo	de of dyi	ng, such as ce	erdiac or	respiratory a	rrest,	1	Approxime Interval Be Onset end	tween
aminer	resulting in death)		URINA			sequence of		)N				1		
physician and street transit adical Examiner	Sequentially list condition if any, leading to immedie ceuse. Enter Underlying Cause (Disease or injury	s, f	b	Due to (	or as a cons	sequence of)						1	7.3	
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certificate has rector, page 2 Be Comp										10	Yes 200 N	0	1 □ Yes 2 ☑	No
director,	25. Was case referred to examiner?								f Death	(Check only	one)			
al di	1 ☐ Yes 2 ☐ No 27. Manner of Death	Pending	28a. Date of Ir		28b. Time Injur	o of	28c. Inju Wo	ry at rk?	2		idence 6 D		cify)	
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	2 Accident 3 Sulcide 6 4 Homicide	investigation Could not be determined	28e. Place of building,	Injury - At h etc. <i>(Speci</i>	ome, farm, fy)	street, facto		Yes 2 □ No		8f. Location ( City or To	(Street and N wn, State)	umber or Au	ural Route Nur	mber,
Me Funeral pletely filled edical C	29a. Certifier 12 C (Check only 2 M	ertifying Phy edical Exami	sician: To the besiner: On the basis and manner	of examina	owledge, de ation and/or	ath occurred investigation	at the ti	me, date and popinion, death	place, ar	nd due to the d at the time,	cause(s) and date and pla	I manner as ce, and due	s stated. to the cause(	(s)
To the	29b. Signature and title of	certifier		1.		29	c. Licen:	se number			29d. Date si	gned (Mont	h, Day, Year)	471.5
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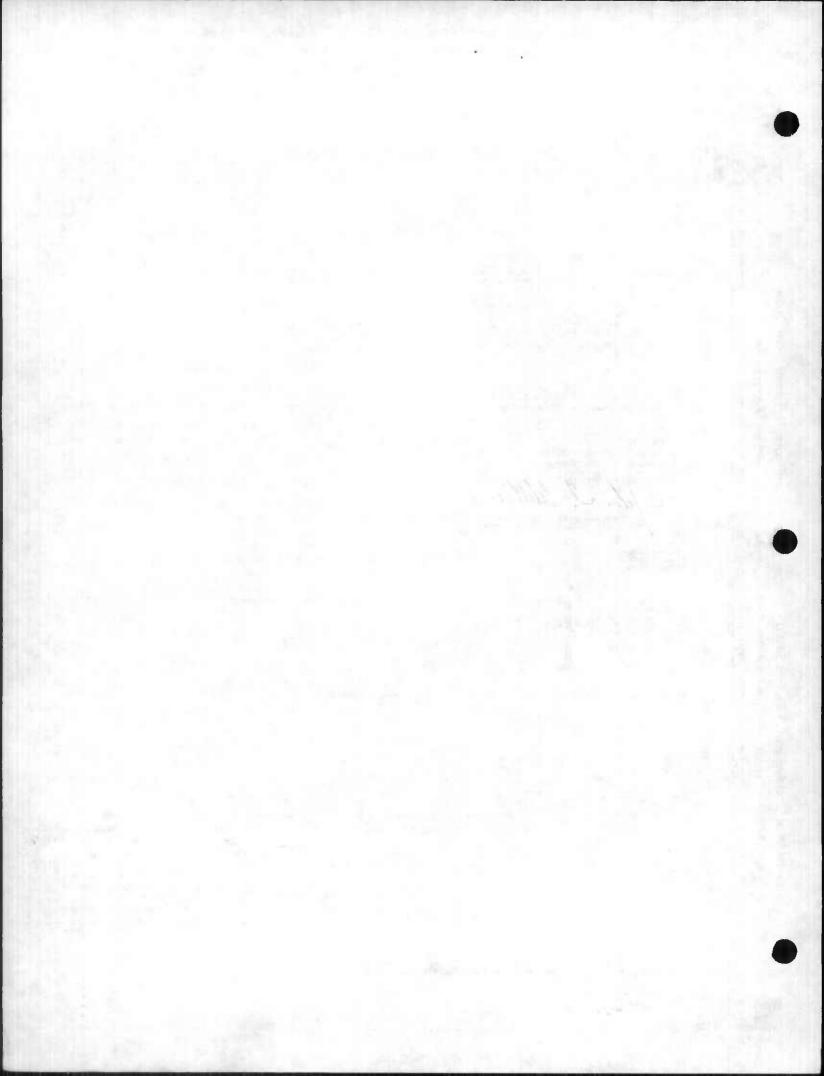
00-6309-045 JOHN DENTON JV

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W	AMEND ITEM:	28C PER PHY G790 12-29	State of Maryland		rtment of tificate of			iene (	)0	37377
		1. Decedent's Nama (First, Middla, La	sf)				2. Data of Deat Month	h Day	Yaar	3. Time of Death
	Physician /Medical	JOHN ARNOLI	D DENTON, 3	JR.			NOVEMBE			2:10 P.M.
	Examiner	4e Facility Name (If not institution, giv				4b. City, Town	n, or Location of Death	4c. County	of Death	
			GENERAL HOSPITA			SALISI			COMIC	
	Funeral Director	068-56-26/5	7. Age (In yrs. In 41	asi birthday) Yrs.	Months Deys		Min. 8. Date of Birth (Month, Day, 07/30/1		9. Birthp Coun NEW	plece (Stata or Foreign htry) YORK
	pu ***	Usual Rasidence of Decedant  10a. State 10b. County	10c. City	, Town or Loc	ation		1-0		1	Od. insida City Limits
	r 28a-f show notified at	VIRGINIA ACCOMA	CK	PUNGOT	FAGUE					1 ☐ Yas 2 No
	or 28a-f s or 28a-f s be notified Director	10e. Street and Number			10f. Zip Code		11	Og. Citizen of V	Vhat Coun	itry?
	th will	15521 PUNGOTE	AGUE ROAD		2342			U.	S.A.	
	r freme 23	11. Merital Status	12. Was Decedent Ever in U,S Armed Forcas?	S. 13. W	Vas Decedent of Yes, specify Cu	Hispenic Origin ban, Maxican, f	n? (Specify Yas or No- Puarto Rican, etc.)	14. Rac		ean Indien, atc.
21215-0020	urs a	1 Nevar Merried 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 No If Yas, Giva Yaar or Dates:		□ Yas 2X No		T. C.	Specify	· WH	ITE
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lan	ould be fi Mental H arked off atte ever	JOHN ARNOLD DEN	TON. SR.			JOAN	ELIZABETH	WRIGHT		
Maryland	s mar s mar	19a. Informant's Name/Ralationship (	Type, Print)			and Number	or Rural Routa Number	City or Town,		
	and 2 palth a 27 la	MICHELE LYNN EV	ANS DENTON/SPOUS	SE 155	21 PUNGO	TEAGUE	RD., PUNGO	TEAGUE,	, VIR	GINIA 23422
Baltimore	of He	20a. Mathod of Disposition 1    1    Buriel 2 □ Cremetion 3 □	^4	iace of Dispos emetery, cram	sition (Nama of atory or othar pl	aca)	Data	20c. Location -	City or To	wn, Stata
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Bal	permit. Pag Department Important: I any Injury o	21. Signatura of Funeral Sarvice Licer	Milliams	22.	Nama and Add	rass of Facility	WILLIAMS FUN	ERAL HOME		
_	20240	C John V.					KET ST., ONANG		RGINIA	23417 Approximata
	Physician /Medical Examiner	23a. Part1. Inter the disease, or comshock or heart failure. List only  Immediate Causa (Final disease or condition resulting in death)	M		PLE		JRIES		1	Iritarval Between Onsat and Death
Box 68760,	at the death certificate be executed d by the attending physician and etached for use as the burial-transit Physician/Medical Examiner	Sequentially list conditions, if any, laading to immadieta cause. Enter Underlying Cause (Disaasa or injury that initiated avants resulting in deeth) Last	c	r as a consequ						
	death e atte ad for	Part II. Other significant conditions of	ontributing to death but not rasu	ulting in the un	derlying cause g	ivan in Part I.	23b. Did to	bacco uae co	ntribute to	o the cause of death?
P.0							1 🗆 Y	es 2 000	3 Pro	bably 4 Unknown
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<b>Division</b>	ttending death. ctor: After y the fune	27. Mannar of Death  1 Naturel 5 Panding invastigation  3 Suicida 6 Could not b determined	28a. Place of Injury - At ho building, etc. (Specify	28b. Tima of Injury 1228 oma, form, stre	et, factory, office	XYas - 2/10 N	AND THEN	STRUCK	BY AND TAKE	LIVER OF TRUCK NOTHER VEHICLE ESECTING D214E BARDERS, CAND 693, CINIA
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	Within To the comple	29b. Signature and tile of certifier				nse number	2	9d. Date signe		
		1 / /	I m	1.	0	.C.M.E.		NOVEMB	BER (	07,2000
	1.07	30. Nama and address of person who		23a) (Type, f	Print)					
		MARY G. RI	PPLE, M.D.		Penn Str	eet, Ba	ltimore, M	aryland	2120	01
	State	31. Data filed (Month Cay, Year) 4	32. Registrar's Signat	Tura 4	don	1				

DHMH 16 Rev 6/95

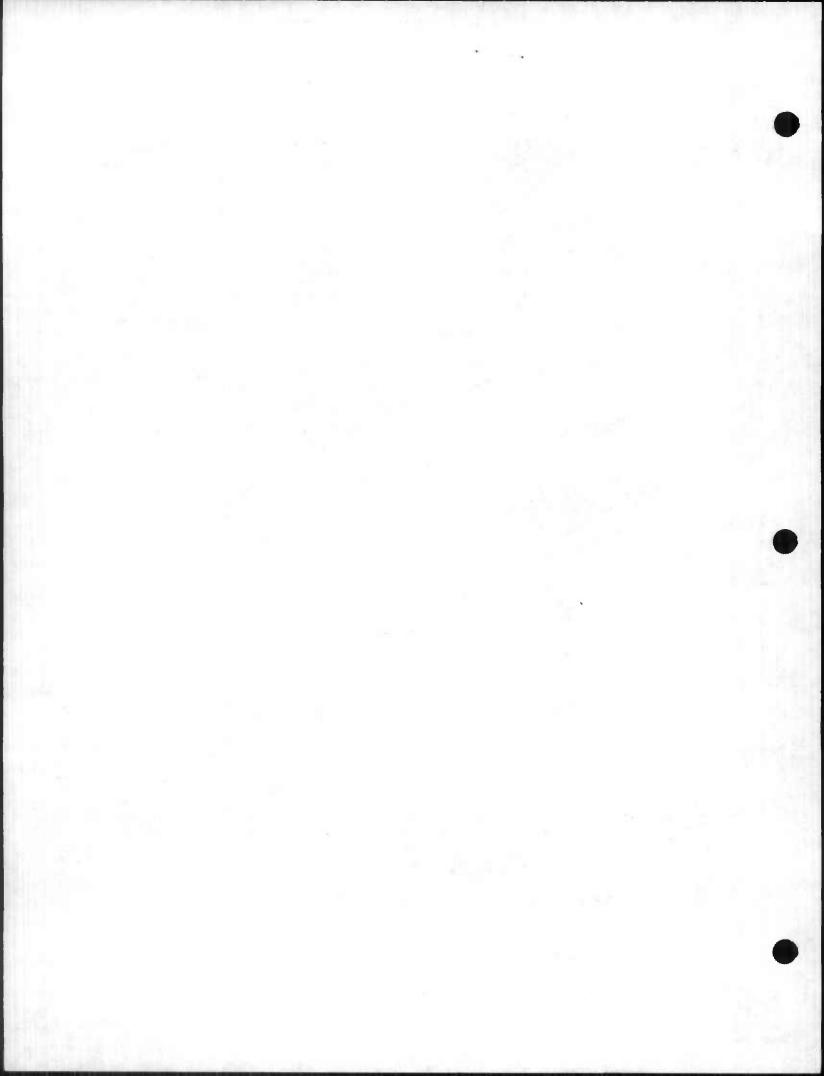
State Registrar



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State of Maryland / Department of Health and Mental Hygiene 00 37378

Physician					001		Death		P	eg. No.		
	1. Decedent's Nam	ne (First, Middle, La	est)		377				2. Date of Dea Month	th Day	Year	3. Time of Death
		ALBERT	DeBELL	-A					Nov.		000	6:00 AM
/Medical Examiner		(If not Institution, gi					4b. City, Tov	vn, or Loc	ation of Death	4c. County		
LAUIIIIII		200 Arc	tic Ave.				Ocean	Cit	v	Word	ester	
uneral	5. Social Security I		Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under a		8. Date of Birth (Month, Day			ace (State or Foreig
irector	186-03-8	8872	1 M 2 F	0.0	Yrs.	Months Days	Hours	Min.	ept. 3	1914	PA	(y)
rector	Usual Residence of			86				Ψ.	cpr. J	1314		
* # S	10a. Stata	10b. County		10c. Ci	y, Town or Lo	cation					10	d. Inside City Limit
4 9	MD	Worces	tor	0	coon C	: 4						XXYes 2 N
or 28a-fa be notified Director	10e. Street and Nu		ster	0	cean C	10f. Zip Code		-		l0g. Citizen of \	What Count	rv?
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for cust		ctic /tvc							<u> </u>			n to don
E	11. Marital Status		Armed Fo		,S. 13. V	Vas Decedent of I Yes, specify Cub	an, Mexican	, Puerto R	ican, etc.)	Blac	ce - America ck, White, e	
S L		ried 2 Married	1 X Yes If Yes, G	2□No ve WWI		☐ Yes 2 No	Specify:			Specify	v: 1A/1	nite
	3 N Widowed	4 Divorced	Year or D	ates:		^					AAT	nte
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marked other then imarks event, the Mr. To Be Comp	17. Father's Name	(First, Middle, Las	t)				18. Mothe	r's Name	(First, Middle.	Maiden Suman		
erked ordc ev	Jose	ph DeBel	la				Gen	eva	Savaga			
T TOTAL	19a Informant's N	Name/Relationship	(Type Print)		19b. Meilin	g Address (Street					State, Zio	Code)
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mportant: h		5 Other (Speci		H	oly Cro	oss Ceme	etery	111-	-13-00	Yeadon	, Pa.	
mportant: If any Injury or ance.	21. Signature of	uperal Service Lice	insee/		22	. Name and Addre	ess of Facilit	y The	Burh	age Fur	neral	Home
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	23a Part Entel	the disease, or con	nolinations that	caused the dea	1						-	Approximate
- 20	shock, or her	ert failure. List only	one cause on	ech line.	III. DO HOL BIIL	er the mode or dy	ng, adon da	cerdiac or	respiratory an	001,		Interval Between Onset and Death
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etached for us Physician	Part II. Other eigni	ificant conditions	contributing to d	eath but not res	ulting in the u	nderlying ceuse gi	ven in Part I		23b. Did t	obacc <i>o</i> uee co	ontribute to	the cause of death
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Ce	rtitica	ite of	Death	7		Reg. No.			
		1. Decedant's Nama (First, Mid	Idia, Lasi	)			7/11				2. Data of De			3. Time	of Death
Physic /Med		Barbara Elizab							di Ob. T	our eal	Novem	ber 12		-	530
Exami	ner	4a Facility Nama (If not institut	ion, giva	street and nu	mber)				4b. City, I	own, or L	ocation of Deal	n 4c. Cou	inty of Death		
		Washington Cou	-				1 411			gerst			hingto		
Funeral		5. Social Security Number	6. Se	X JM 2DF		yrs. last birthday	Month	ar 1 Yaar s Days		r 24 Hrs. Min.	8. Data of Bi (Month, Di	rth ay, Year)	9. Birth	placa (Stat ntry)	a or Foraign
Director		559-30-5452		A(	75	Yrs.					Dec.	5 1924	Cali	forni	a
2 *		Usual Rasidance of Decedant 10a. Stata 10b. Coun	itv		10c	. City, Town or L	ocation							10d Inside	City Limits
5-0020 72 hours after death with the Maryland natural, or items 23s or 28s-f show ates Examiner must be notified at	Director	Maryland Wash		on		Hagers	town				T			1 🗆 Y	as 21 No
de la	F	10e. Street and Number					10f. Z	Iip Coda					of What Cou	ntry?	
£ 23	rai	21100 Mount Ae	tna					217					J.S.A.		
lr de	Funeral	11. Marital Status	-	12. Was Dec Armed Fo	orcas?	n U,S. 13.	Was Dec	edant of to ecify Cub	Hispanic O pan, Maxica	rigin? (Sp an, Puarto	ecity Yas or No Rican, atc.)		Race - Amari Black, Whita,		
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d 2121 filed within Hygiena. other than "	E	12	'	2	1-401 34)	Но	memal	cer				Her	own he	ome	
Iryland 212. should be filed within and Mental Hygiena. marked other than imatic event, pr. y.	BeC	17. Fathar's Nama (First, Middle	a, Last)						18. Moth	ner's Nem	e (First, Middle				
ylan Suld be Mental Mental Mental	ToB	Eldon Price							Ger	neiev	e Evely	n Spar	naus		
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event	-	19a, Informant's Name/Relation	nship (T)	rpe, Print)		19b. Mei	ing Addra	ss (Street			ral Routa Numb			p Code)	
Ma 2 and 2 a		Linda Havens -	- Dat	ohter							d Hage				2
ore, Maryland 2121 s 1 and 2 should be filed within of Health and Mental Hygiena. Item 27 is marked other then other traumatic event, tree		20a. Mathod of Disposition	Dat	AGIICCI	20	b. Place of Disc	osition (A	leme of		1 1100	Data		on - City or T		
0 00 = =		1 Burial 2 □ Cramation 4 □ Donation 5 □ Other				Rest Hav				11	/15/00	Hager	stown,	Mary	land
Baltim pemit. Pag Department Important: I any Injury o		21. Signatura of Funeral Sarvio			1	1.6			ass of Faci		nnich ]				
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Physician /Medical		Immediata Ceuse (Final		0										,	
Examiner	100	disaasa or condition rasulting in death)		a. /	NEU	MONI	4						i i	101	)
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sit ed	Examiner			Co Co	NGB	STIV	Et	1 EA	RT	MAIL	-URF	3	į	10>	
and and	xan	Sequentially list conditions,			Due t	o (or as a conse	quance o	f):							
68760, ficata be ev physician is the buria		Sequantially list conditions, if any, laading to immediate cause. Enter Undarlying Causa (Disaasa or Injury that initiated events		c. D1	ABI	ZTES	M	ELL	-1516				į	10 Y	
Shysii the t	edical	that initiated events rasulting in daath) Last			Duat	o (or as a conse	quenca o	f):	7					(	
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BO ath c	lan/							A. The					1	3	
the a	sic	Pert II. Other aignificant condi	tions co	ntributing to d	laath but not	rasulting In tha	undarlying	causa gi	van in Part	1.	23b. Did	tobacco uad	contribute	to the caur	se of death?
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S ta tight	by										-		1 - 11 11		
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0 > 0	ple												0	ompletion of death?	or causa
The law	E										10	Yas 25 N	0 1	☐ Yas 2	2□ No
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Division  I or Attending after death.  Director: After d in by the fune	-T	4 Homicida	IIIIIII		ing, atc. (Sp	ecify)		.,,			City or To	wn, Stete)			
Division o  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical		ner: On tha b	asis of axen	knowledge, dae ninetion end/or i									a(s)
the the	Med	one)	flac	and man	nar statad.		1.	Oo Lines	oo number			20d Date -	anad /least	Day Vos	e)
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		30. Nama and address of person	on who co	omplated caus	sa of daath (	Itam 23a) (Type	, Print)					10.01			
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MSON, Barbara Elizabeth 00B12-15-1924 Expirilos30 11/12/00

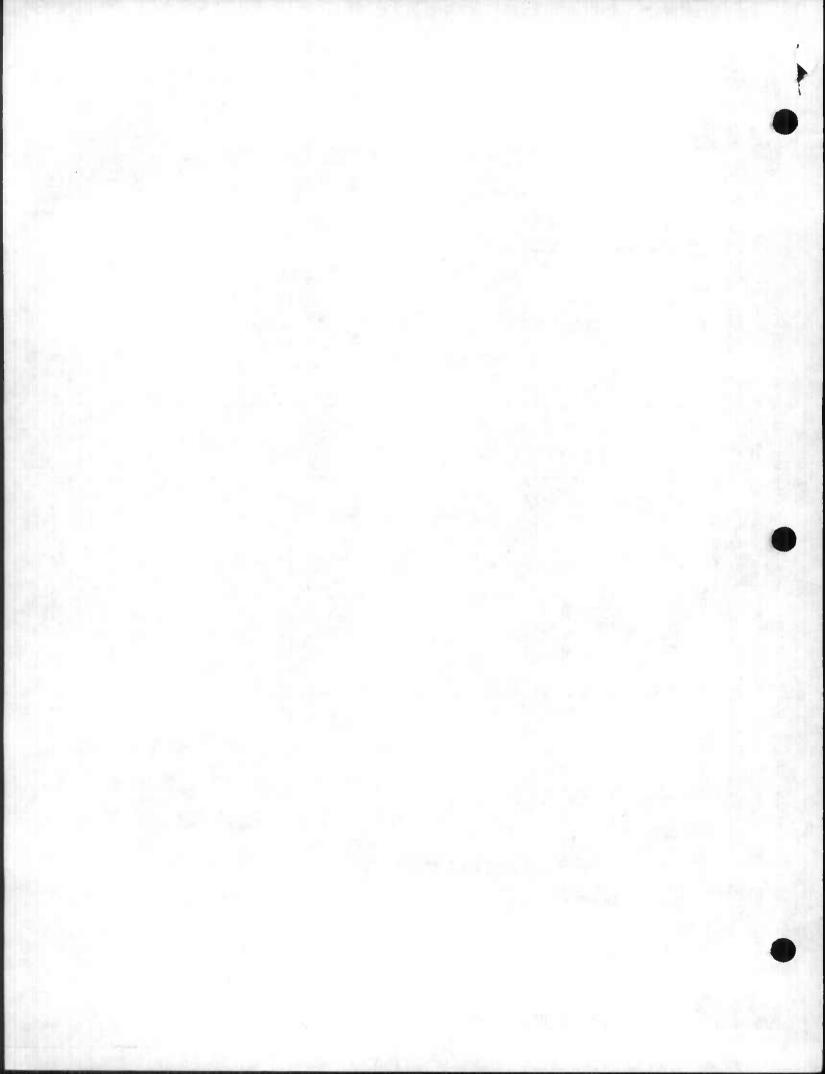
NAME: ERICKSON,BARBARA ELIZABETH DOS: 10/31/2000 12/15/1924 75 / F WASEEM, M. KHALID

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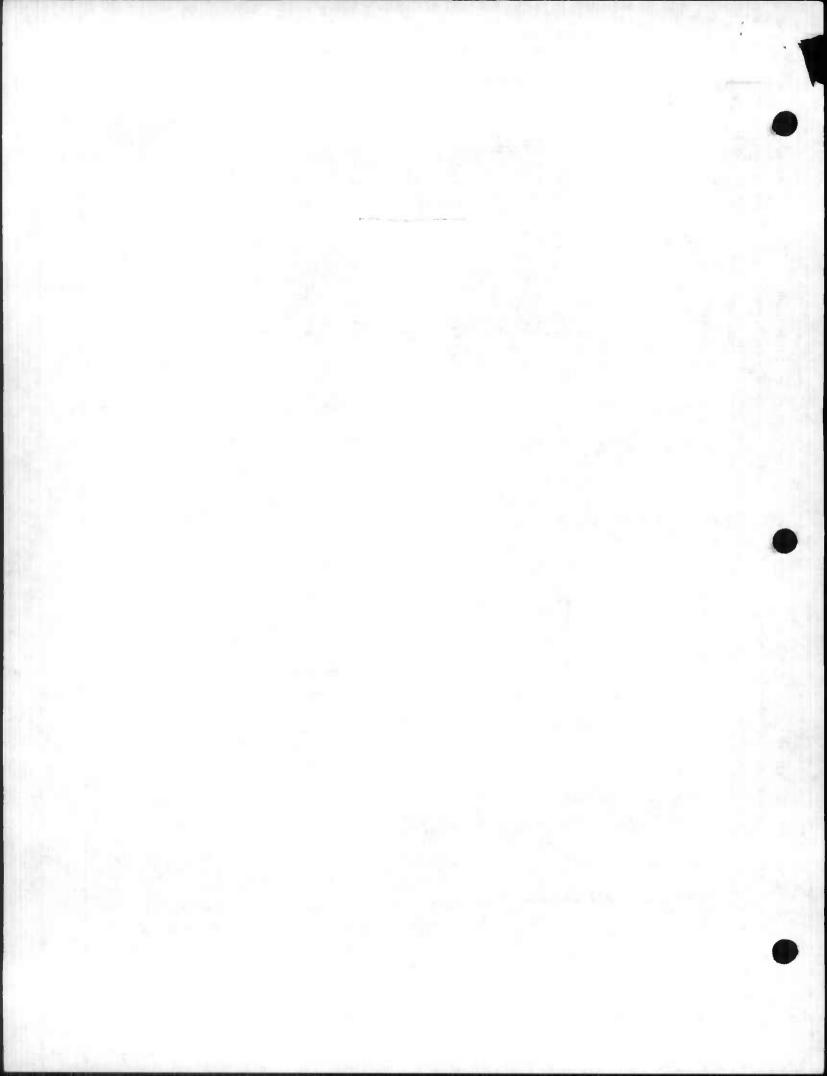
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	Physiciar /Medica	n	Decedent'a Name (First, Middla, Las	Rosamor	nd	Chapin	Edwa	rds	2. Date of Deal Month November	Day	Year 000	3. Tima of 1	
	Examine		4a Facility Nama (II not Institution, give 5001 Feeser Road					4b. City, Town, or L		4c. County	of Death	ounty	
	Funeral Director		330-10-7323	ex 7. Ag □ M 2 X F	a (In yrs. 93	N. A	f Undar 1 Ye Months Day		8. Data of Birth (Month, Day, Sep. 13	Year) 3 1907	9. Birthple Count New	aca (Stata or ry) York	Foreign
	how		Usual Rasidance of Decedent  10a. Stata 10b. County		10c. Ci	ty, Town or Locat	ion				10	d. Insida Cit	
	Se-f a	Sctor	Maryland Carroll		Ta	neytown						1 🗆 Yas	2 No
	3a or 2	a Dir	10e. Stoleed Numberser Roa 4931 Feeser Roa	d West			10f, Zip Code	21787		og. Citizen of V United			
020	72 nous aner deam with the maryland natural; or items 23a or 28a-f ahow otes Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Nevar Marriad 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedant Armed Forces? 1 ☐ Yas 2 ☑ I If Yes, Giva Year or Dates:			s Decadant cas, specify C	f Hispanic Origin? (Si uban, Maxican, Puert lo <i>Specify:</i>	pecify Yas or No- o Rican, atc.)	Blac	e - Amarica ck, Whita, a	tc.	
121	E	Completed	15. Decedent's Ed (Specify only highast gra Elementary/Secondary (0-12)		5+)	lifa. DO	t's Usual Oc d of work do NOT usa rat homema	na during most of wor ired)	king	own he		ustry	
	other went, the	Be C	17. Fathar's Nama (First, Middla, Last)			2.245		18. Mothar's Nam	ne (First, Middla, I	Maidan Suman	na)	111	
Maryland	and Mental Hygiena.  marked other than sumatic event, the M	0	Whelan A. Cha						Mae Haugh				
Mai	and 2 st salth and n 27 is m er traun		19a. Informant's Name/Ralationship (7 Sydney W. Keller		_			Road West		eytown,			
· ·	parmit. Fages I and Z. Department of Health at important: If item 27 is any injury or other tras bace.		20a. Mathod of Disposition  1 VBurial 2 Cramation 3 4 Donation 5 Other (Specify	Ramoval from Stata	20b. I	Place of Dispositi cemetary, cramat	on (Nama of lory or other)	ofe co.)	Nov 7	20c. Location -	City or To	wn, Stata	nd
Balti	Department Important: Fag any injury o		21. Signatura of Funaral Sarvice Licen	Skiles		22. N	lame and Ad	trace of Espility	Skiles F	Uneral	Home	, MD 2	
	Physician /Medical Examiner		23a. Pin Z. Enter the disease, or companies, or haart faitura. List only in the companies of the companies o	olications that caused on a cause on a ach life a. As PII	ZAT		PNE	dying, such as cerdiad	or respiratory arr	ast,		Approximata Interval Batwonset and D	veen
Box 68760,	incate be ig physicia as the bur	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last	C	ROV Dua to (d	ASCULI or as a consaquer or as a consaquer	AR nce of):	Accide	ENT			12 >	RS
B.	the attending	Physician/M	Part II. Other significant conditions or	ontributing to death b	ut not ras	sulting In the unde	arlying causa	given in Part I.	23b. Dld to	obacco uae co	ntribute to	the cause o	of death?
P.O.	ned by the attendir	by Phy				9.6			1 🗆 Y	• 2 No	3 Prob	ably 4 🗆 l	Jnknow
of Vital Records,	has been signed by the	Completed							24a. Was a perfor	in autopsy med?	ave	re autopsy fi ilabla prior to nplation of co leath?	0
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Vit	0 2	0 20	25. Was cesa rafarrad to medicel axaminar?  1 ☐ Yas 2 ☒ No	Hospital:	ant 2	ER/Outpatient	3□ DOA	Other	ath <i>(Check only or</i> Ioma 5 N Resid		er /Snecih	,)	
ion of	5 5 8		27. Mannar of Death  1 Natural 5 Panding 2 Accidant Investigation	28a. Data of Inju (Month, Da	ry	28b. Tima of Injury	28c. li	njury at Vork?	28d. Dascribe h			,	
5	vithin 24 hours after death within 24 hours after death completely filled in by the funeral	Certification:	3 Suicida 6 Could not be determined	28a. Place of tnj building, at	ury - At h c. <i>(Speci</i>	oma, farm, straat fy)	t, factory, offi	Ce	28f. Location (S City or Tow		ber or Rura	Route Numi	ber,
	within 24 hours To the Funeral	edical			axamina			tima, data and place y opinion, death occu					)
	Within To the comp	Z S	29b. Signatura and titla of certifier	00		11.50%		ansa number		29d. Data signa			1
			30. Nama and address of person who	completed cause of d	1	m 23a) (Type, Pri	mt)	D03005	6E	Nov.	5,	2000	0
			THOMAS D- RA			848 B	ROADU	UAY, H	LANOVE	R, F	4 17	331	
۰	State Registra		31. Data filed (Month, Day, Year)	32. Ragistr	ar's Sign		1						



Amended Item #10c, Per F.D., 11/08/2000, Carroll County, crw
Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible.

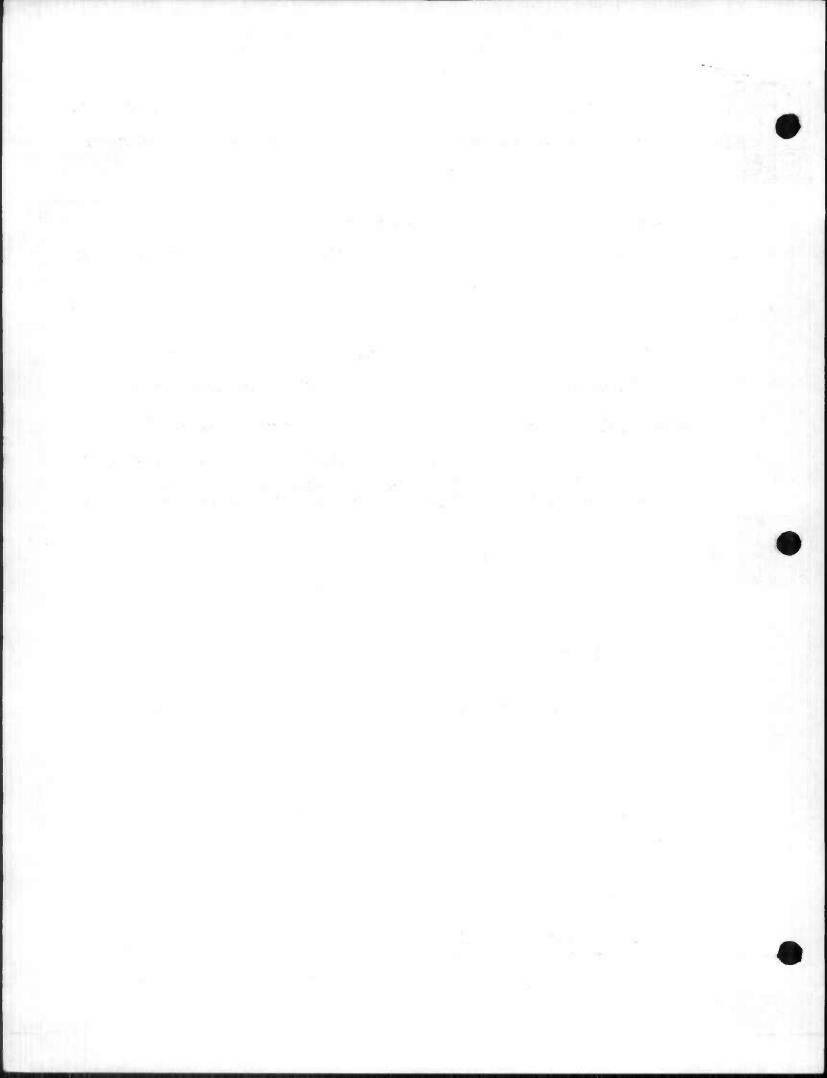
3738 Amended Item 23b, Per Phy. 11/16/2000, Carroll County, wil Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death 2 Date of Death Month Year **Physician** 1c 1190+ ICh 4. Wan Nov 2000 /Medical 4e Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Sylvesuille Copper Carrol 6. Sex 1 M 2 ☐ F 7. Age (In yrs. lest birthdey) If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Jan. 18, 5. Social Security Number 9. Birthplace (State or Foreign Year 1914 **Funeral** Deys Wisconsin Yrs. 388-07-2593 **Director** Usual Residence of Decedent 10c. City, Town or Location Sykesville 10a. Stete 10b. County 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2 No MD kesville Carroll Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 710 Obrecht Road 21784 U.S.A. Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or hams 11. Marital Status Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Real Estate Realtor 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Pages 1 and 2 should be to ment of Health and Mental H ant. If them 27 is merked off Arthur Ehrlich Nellie (Unknown) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 22911 19a. Informent's Name/Relationship (Type, Print) Mrs. Phydele Ehrlich (Wife) 250 Pantope Mountain Rd #322 Charlottesville, VA 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State All County Cremations Srv.11/6/00 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) ě i 8 Sykesville, MD 21784 (4100-795-1400 Approximete Interval Between Onset end Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List onty one ca ors that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical immediete Cause (Finel disease or condition Examiner resulting in death) Due to (or es a consequence of). Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pug Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed by The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 1 ☐ Yes 2 ☑ No 2 - No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 3 DOA 27. Menner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Alaturel 5 Pending after death. 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, larm, street, lectory, office building, etc. (Specify) 5 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 11/03 mestin 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) 1

Ernestive Write Copper Ridge kesville, MD 10 Obrecht Road Coppen Ernestine 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar NOV 0 8 2000 DHMH 16 Rev 6/95



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Registrar



## Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Mary Funny 02_2000 11:38 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 515 Cloves Avenue Capitol H Heights Prince George's 5. Social Security Number If Under 1 Year 7. Age (in yrs. last birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 2 F Months Days Hours Min. Yrs. Director 577-64-4982 7/27/1912 88 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits piena. r than "natural", or itema 23a or 28a-f show the Medical Examinat must be notified as 28a-f show 1. Yes 2 □ No Funeral Director DC Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 Constitution Avenue, N.E. 20002 U.S.A. 2 should be flied within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black py 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Unknown Unknown is marked 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2: Department of Health a important: if item 27 is any Injury or other trau once. Jannie Luck/ Niece 515 Cloves Avenue, Capitol Heights MD 20743 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 5 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 11/09/00Quantico, Virginia Quantico National Taral Service Licensee 22. Name end Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD Party Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Examiner Due to (or as e consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that included acceptance) the burial-trar Due to (or as a consequence of): been signed by the attending physician should be detached for usa as the buria Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown py 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Completed After this certificate has 1 ☐ Yes 2 ☐ No apital or Attanding Physician: Thours after death.

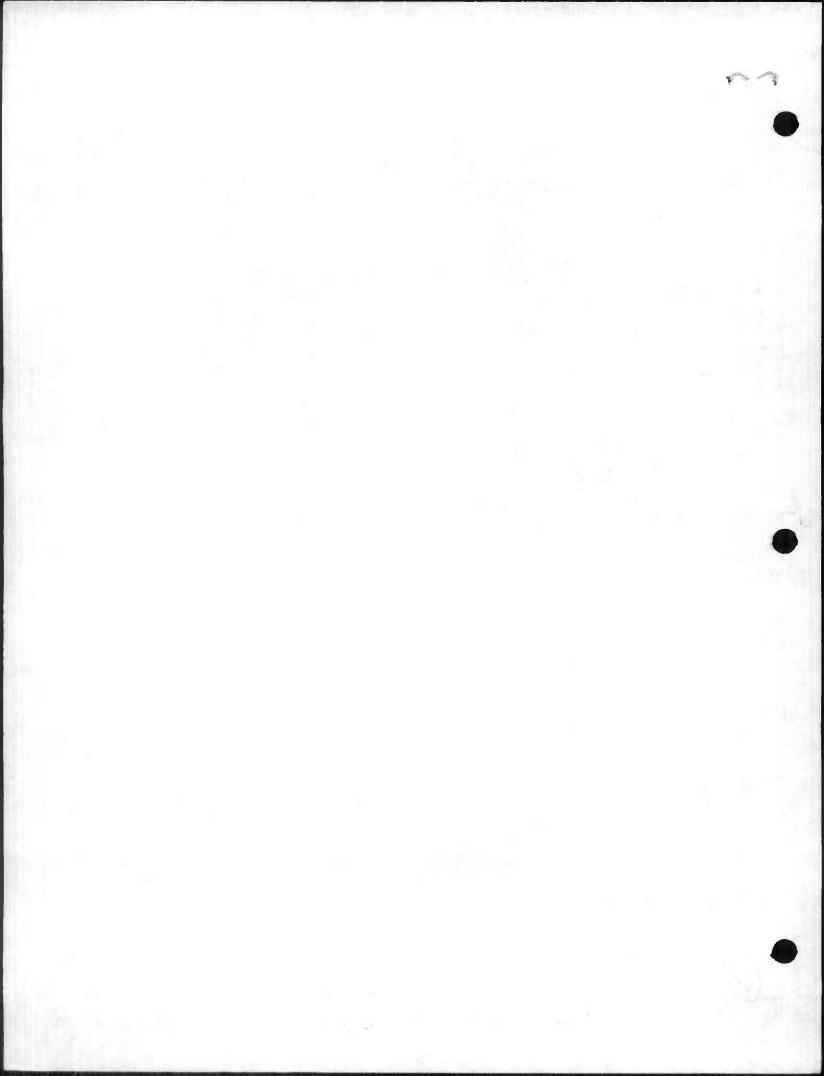
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y filled in by the funeral director, p Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural
2 ☐ Accident 5 Pending investigation 1 Yes 2 No 281. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MUSTELLER 00 contrib 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leách 9500 Annapolis Road Suite A-1 Lanham, Maryland 20706 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State NOV 0 7 2000

**DHMH 16 Rev 6/95** 

Registrar

**ORIGINAL** 



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State of Maryland / Department of Health and Mental Hygiene UU

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COLETTE FRA7

Certificate of Death

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	1. Decedent's Neme (Fin	st, Middle, Last)			2. Dete of Deeth Month	Day Yaar	3. Time of Death
hysician /Medical	Colette	Nichole	Frazier			R 2,2000	2:30P.M.
	4a Facility Nema (If not i	institution, giva street a	and number)	4b. City, Town, or	Location of Death	4c. County of Death	
	OUSS VINIADO	TTC DOAD		TANTIAN		DOTNOTE CEC	DOTEC

**Funeral** Director

> "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at

than

waryland
Weparmet Pages 1 and 2 should be file
Weparment of Health and Mental Physician limportant. If item 27 is market 1999
any injury or other?

filed within 72 hours after

Baltimore, Maryland 21215-0020

Directo

Funeral

Ag

Completed

Be

9023 ANNAPOLIS ROAD If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Y Jan. 26, 9. Birthplace (Stata or Foraign 5. Social Security Number 7. Aga (In yrs. last birthday) Year) 1976 Days Hours 1□M 2X)F 24 Yrs. Takomá Park, MD 218-17-9605 Usual Rasidance of Decedant 10a. State 10b. County

Prince George's

10c. City, Town or Location Highland Park 10d. Inside City Limits

10e. Street and Number

11. Medtel Stetus

10f. Zip Code

₩ Yas 2 No

1113 Fiji Avenue

Never Merried 2 Merried

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yas, Giva

 Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 1 ☐ Yes 2 ☐XNo Specify.

20785

14. Race - Amarican Indian, Black, Whita, atc. BLACK

3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated)

Collega (1-4or 5+)

3 YRS.

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)

STUDENT

16b. Kind of Businass/Industry N/A

10g. Citizen of What Country?

USA

Elementary/Secondary (0-12)

17. Father's Nama (First, Middle, Last) Sylvester Raleigh Frazier 18. Mothar's Nama (First, Middla, Maidan Sumama)

Paulette Feggins

19a. Informant's Name/Ralationship (Type, Print)

19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1113 Fiji Avenue Highland Park, Maryland

Paulette Frazier/ mother 20a. Mathod of Disposition

20b. Place of Disposition (Nama of cemetary, crematory or other place)

Data 20c. Location - City or Town, Stata

1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Specify)

Metropolitan Crematory

11-4-00 Alexandria, Virginia 22. Name and Addrass of Facility Marshall's Funeral Home of MD

21. Signeture of Funeral Service License

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4308 Suitland Rd. Suitland, Maryland Approximata Interval Batween Onset and Deeth

**Physician** /Medical Examiner

ed by the attending physician and detached for use as the buriel-tran

been signed by t should be detach

page 2 should

aplat or Attanding Physician: The hours after deeth.

neral Director: After this certificate y filled in by the funaral director, pa

within 24 hours a
To the Funeral C

Hospita

2

by

Completed

Be

10

Certification:

edicai

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

wound of quishot Dua to (or as a consequence of)

Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaase or Injury that initieled evants rasulting in death) Last

Immediete Ceusa (Final disaasa or condition rasulting in daath)

Dua to (or as a consequence of):

Due to (or as a consequence of)

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? Limited

24b. Wara autopsy findings available prior to completion of cause of death?

1⊠ Yas 2□ No

26. Placa of Death (Check only ona)

1 XYas 2 No

25. Was casa rafarred to medical examinar? TY Yas 2□ No

> 5 Pending invastigation 6 Could not be datarmined

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury
(Month, Day Yaar)
FOUN A

11-2-2000 UNKnown

28c. Injury at Work? 1 Yas 2 No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) SCENE 28d. Dascribe how Injury occurred shot self subject

29a Cartifiar

27. Mannar of Death

1 Natural

2 Accidant

3 ☑ Suicide

4 Homicida

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) Hote

Location (Street and Number or Rural Routa Number, Rd. Prince Georges County, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signeture end title of certifier

29c. License number O.C.M.E.

NOVEMBER 3,2000

29d. Date signed (Month, Day, Year)

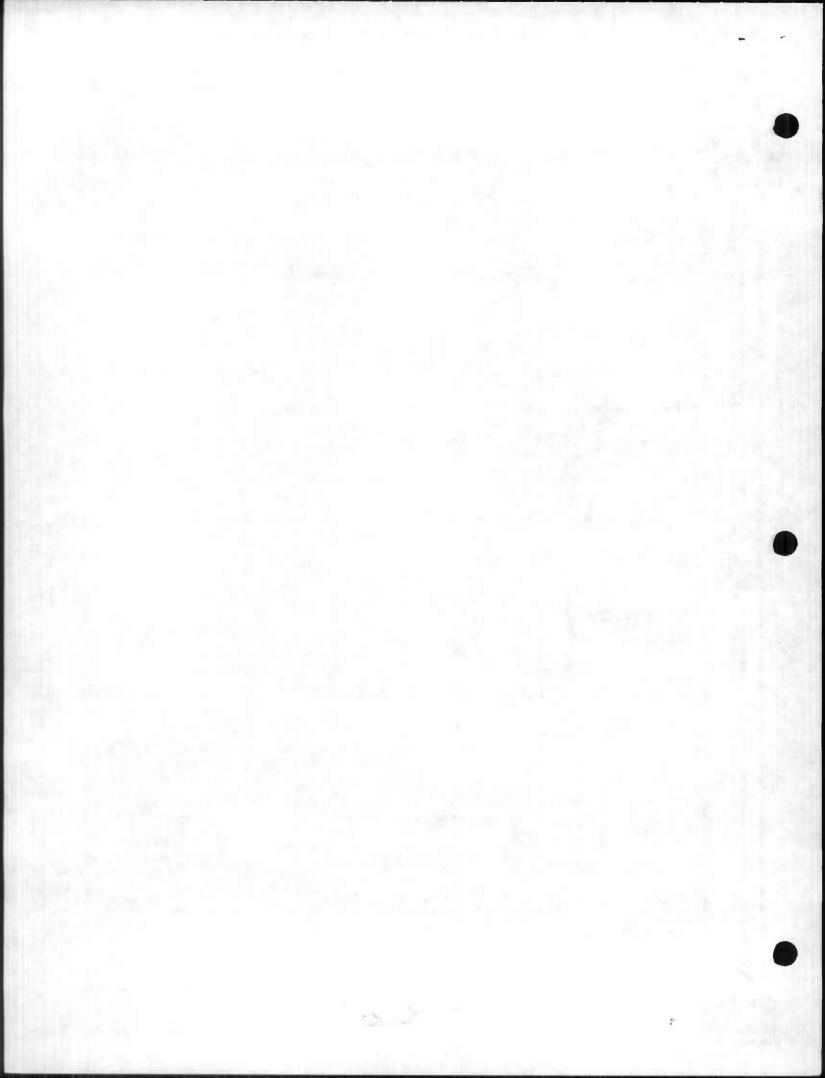
30. Nama and addrass of person who complated causa of death (Itam 20a) (Type, Print)

Stephen 5.
31. Data filed (Month, Day, Year) NOV 0 6 2000

Radent 2 32. Registrar's Signatura 111 Penn Street, Baltimore, Maryland 21201

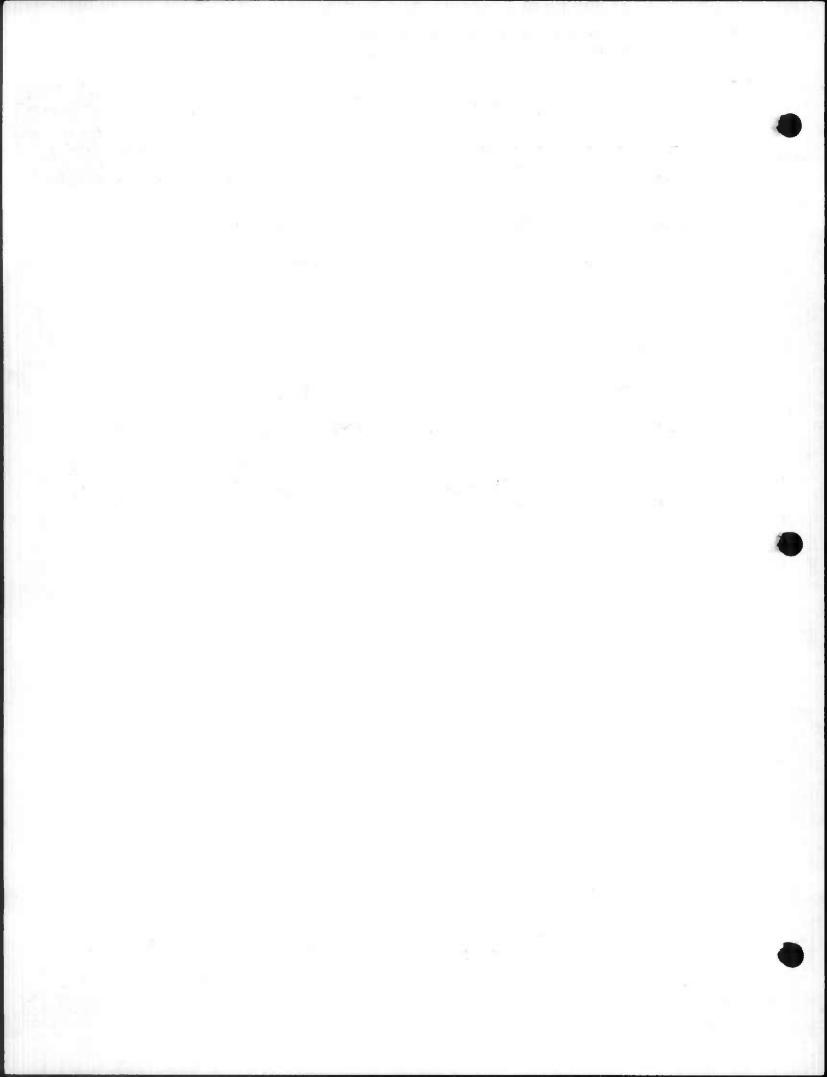
State Registrar

DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certificate d	of Death	R	eg. No.		
			1. Decedant's Name (First, Middla, La	est)				2. Data of Deat	h	Vana	3. Tima of Death
	Physici /Medic		BEATRICE LORR	AINE FRALEY				novem be	Day	Year On O	0157
>	Examir		4a. Facility Name (If not institution, gh	va street and number)			4b. City, Town, or	Location of Death	4c. County		
	c		WASHINGTON COUNT	Y HOSPITAL			HAGERS	COWN	W.	ASHI	NGTON
F	uneral		Social Security Number     6. 5	Sex 7. Aga (In y		Months Da			Year)	9. Birthp	place (State or Foreigntry)
D	irector		217-30-7389	66		Yrs.		JULY 27,			RYLAND
pur	3		Usuai Rasidance of Decedant  10a. Stata 10b. County	10c	City Town	or Location				Τ,	0d. Inside City Limits
Aaryla	show	5			Ony, rom	7 OI LOCATION	Booker	2000			1 1 Yes 2 □ No
he A	r 28a-f sh unotified	Director	MARYLAND WAS	HINGTON		10f. Zip Cod	BOONSI		0g. Citizan of V		
ti w	0 1	ā	41			Tot. Zip Cod		'			
d 21215-0020 filed within 72 hours after death with the Maryland	mant 23a	Funeral	112 PARK DRIVE	12. Was Decedant Evar in	11.5	13 Was Decedent	21713	Specify Yes or No.		J.S.A	ean Indian,
flar	Home Freeze	F	1 Nevar Merried 2 Married	Armed Forcas? 1 ☐ Yes 2 No	10,0.	If Yas, specify C	of Hispenic Origin? (Suban, Maxican, Puar	to Rican, atc.)	Blac	ck, Whita,	atc.
21215-0020 d within 72 hours aft	P. O.	by	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yaar or Datas:		1 ☐ Yes 2 🖾 I	No Specify:		Specify		WHITE
2 50	natural', idical Ex	8	15. Decedant'e E		16a.	Dacedent's Usuel Oc	cupetion		16b. Kind of Bu		
215 hin 7	. 6 5	Completed	(Specify only highast gra Elementery/Secondary (0-12)	ada completed)  College (1-4or 5+)		Dacedent's Usuel Oc (Giva kind of work do lifa. DO NOT usa ra	na during most of wo tired)	orking			
212 d with		E O	7	College (1-401 54)		SE	AMSTRESS		AWNIN	IG MA	NUFACTURE
nd 2	d other	Be	17. Fathar's Name (First, Middle, Last	)			18. Mother's Na	ma (First, Middle, M			
Maryland	27 is marked of traumatic even	To	OTHO (UMN) EATON				IDA (UN	N) BUSSA	RD		
lan 2 sho	S TO		19a. Informant's Name/Ralationship (	Type, Print)	19b.	Mailing Address (Str	eet and Number or R	ural Routa Number	City or Town,	Stata, Zip	Coda)
7 2			WINFRED L. FRALE	Y/SPOUSE	112	2 PARK DRI	VE, BOONSI	BORO, MAR	YLAND	2171	3
Ore of He	f them 2		20a. Method of Disposition		o. Placa of	Disposition (Nama of			20c. Location -	City or To	own, Stata
Pag Pag	int: H		1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		AMPLI	ES MANOR C	EMETERY 1	1/11/00	SHARPSE	BURG.	MARYLAND
Baltimore,	Important: If its any injury or ot once.		21. Signature of Funerel Sarvice Licer	A -	14.2	22. Nama and Ad		7606 01			
<b>m</b> § 8	EES		P. Steven Dar	nfelt Jr.	Lyz	BAST FUN	ERAL HOME	Boonsbo			
			23a. Part1. Enter tha disaasa, or com shock, or heart fellura. List only	pilcetions that caused tha d	aath. Dor	not antar tha mode of	dying, such as cardie			Taria	Approximate
Phy	/sician		SHOOK, OF HEART ISHUIR. LIST OFHY	one ceuse on aach lina.						1	Interval Between Onset and Death
/M	ledical		Immedieta Causa (Final disaasa or condition	Couges	til	Hear	- 7011	1110		1	Weok
Exa	aminer		rasulting in death)	a. Dua to	o (or as a	consequence of):	190	v ce			0
77	*	ner		, Ische	1111'e	1/00	- 70,1e	e an			4 COL
cute	rans	am	Sequentially list conditions,	U.	o (or as a c	consequence of):	4			-	0
0,0	ian a	ũ	Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disaasa or Injury								
. Box 68760, death certificate be axecuted	physician and s the burial-transit	edical Examiner	that Initiated avants resulting in death) Lest	C Dua to	(or as e c	onsaquenca of):					
ortific 6	9 68	2	L	4							
Box	attandir for use	ian/		0.							
O 2	ed by the attand detached for us	Physician/	Part II. Other aignificant conditions of	ontributing to death but not	rasulting in	tha underlying causa	givan In Part I.	23b. Did to	bacco use co	ntribute to	the cause of death
J. 2	ed by detac	Ph	Chremic Obs	tructing 7	Jule	uouaro.	Miteas	104	2 □ No	3 ☐ Pro	bably 4 Unknow
S the state of the		by				7				0.0.11	
Record le law require	been sign should be	Completed						24a. Wes a perform	n autopsy ned?	av	ere autopsy findings eilebla prior to mplation of causa
Rec The law	a 2 s	npi								of	daath?
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Or VItal	this certificate has ral director, paga 2	Be	25. Was casa referred to medical examiner?					ath (Check only on	a)		
Physi	this c	To	1 Yes 2 1√0		□ ER/Ou	tpatient 3L DOA		Home 5 Rasida			ý)
	After t	OU:	27. Manner of Death 1 ☑ Natural 5 ☐ Panding	28a. Date of Injury (Month, Day Year	28b. T		njury et Work?	28d. Dascribe ho	w injury occur	red	
Division or Attending	tor: After the fune	cat	2 ☐ Accident invastigation 3 ☐ Sulcide 6 ☐ Could not b				☐ Yes 2☐ No				
- 54	Director: d in by the	Certification:	4 ☐ Homicida determined		t homa, fa ecify)	rm, straat, factory, offi	ca	28f. Location (St City or Town		er or Rur	al Route Number,
Hospital	To the Funerel Direct completely filled in by	ပိ									
Hosp 24 ho	Fun-	edicai	(Check only 2 Medical Exar	ysician: To the best of my in niner: On tha basis of axam	nowladge ination and	, deeth occurred et the Vor Invastigation, In m	e time, dete end plec ly opinion, daath occ	e, end due to the ce urred at tha tima, de	use(s) end ma ata and placa,	annar es s end due to	tated. tha ceuse(s)
To the	mple	Mec	one) 29b. Signature end titla of certifier	and mennar etated.		29c Lio	ense number	2	nd Data signa	d /Month	Day Veer
P. ¥	2 8	_	200. Orginature end titla of certifier	$\mathcal{D}_{\ell}$		-			9d. Data signe		
,				LONIX			21457		11-9	- 70	,50
			30. Nama end addrass of person who	complated causa of daath (I	tem 23e) (	Type, Print) 1 - OAKH	11 10 11	10.0007	1-10/ 11	40 8	1762
	4711		/ / / / / / / / / / / / / / / / / / / /			I- UKKMI	I KVE. H	44EKS10	WY. M	11) 2	-1174
-117	Sta	100	31. Data filed (Month, Day, Yaar) NOV 1 3 2000	32. Ragistrar's Sig	gratura	Angelal					
1 1	Registr	ar	MON T 2 TOOR			July 1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 3 2000 9:45 AM NOVEMBER MARIE JACKSON FOWLER /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CENTREVILLE **QUEEN ANNE** GENESIS ELDERCARE-CORSICA HILLS If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1□ M 2□XF Months Deys Hours 93 Yrs. Director 283-01 0582 APRIL 20, 1907 MD Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at TY Yes 2 □ No Director **OUEEN ANNE** CENTREVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funerai 205 ARMSTRONG AVE 21617 USA 12. Wes Decedent Ever In U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: by 3 Widowed 4 K Divorced WHITE Completed traumatic event, the Medical 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) WASH D.C. COURT SYSTEM LEGAL SECRETARY 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h end Mental h ROBERT EMMIT JACKSON ELSIE CYLENA KIRBY 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2
Department of Health en
Important: If item 27 is
any injury or other trau SUZANNE L. HOOD/GUARDIAN 32 S. WASHINGTON ST. SUITE #5 EASTON, MD 21601 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) OLIVET CEMETERY 11-09-00 ST. MICHAELS, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA TOAN IZ, MERCERON CEST 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ne my min Examiner Due to (or es e consequence of): physician end the buriel-trans Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In death) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of) Pert ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evelleble prior to 24a. Was en eutopsy performed? Completed i mounds. completion of cause of deeth? 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No certificate 25. Wes cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of injury (Month, Dey Year) 27. Marmer of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: After Neturei 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion Director: 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide n 24 hours e Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medicel Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) To the F within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/3/2000

30. Nemo and eddress of person the completed cause of deeth (Item 23e) (Type, Print) Or we Chick, Ms 2/6/9

parks

32. Registrar's Signeture

State Registrar

31. Dete file

Baltimore, Maryland 21215-0020

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C

01:10

m

PK-945-MarieFowler

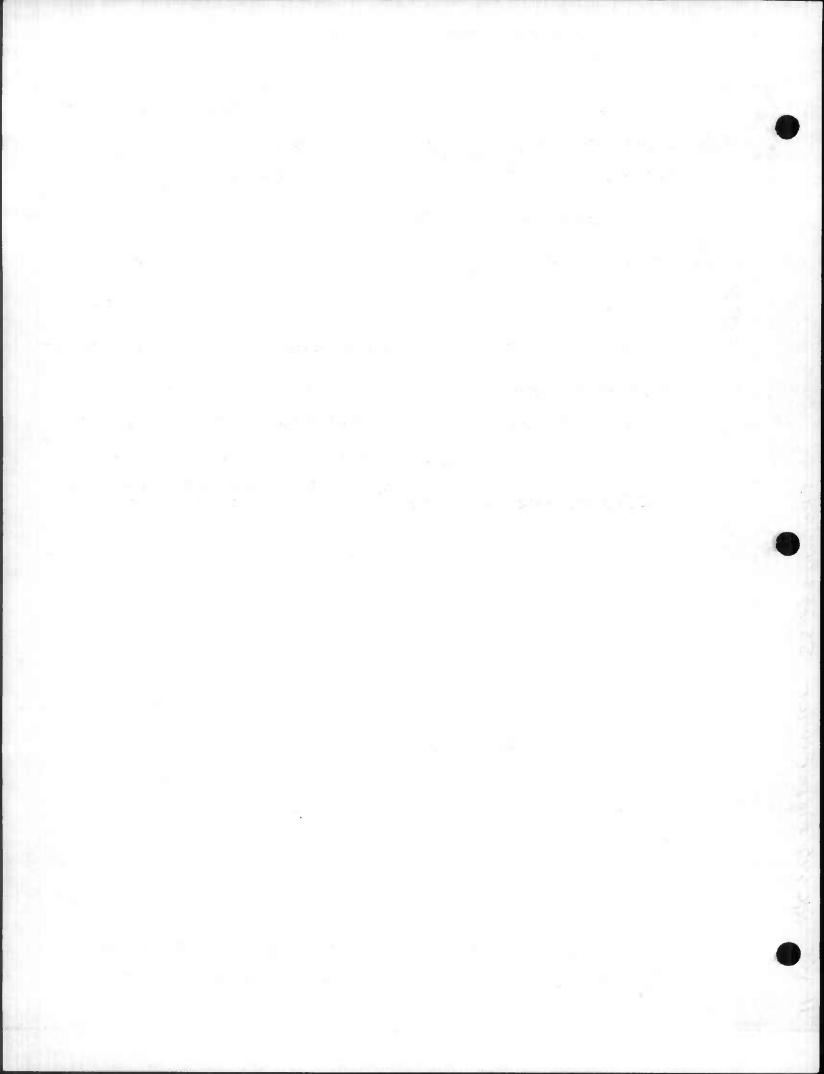
Box 68760.

Records,

Division of Vital

death.

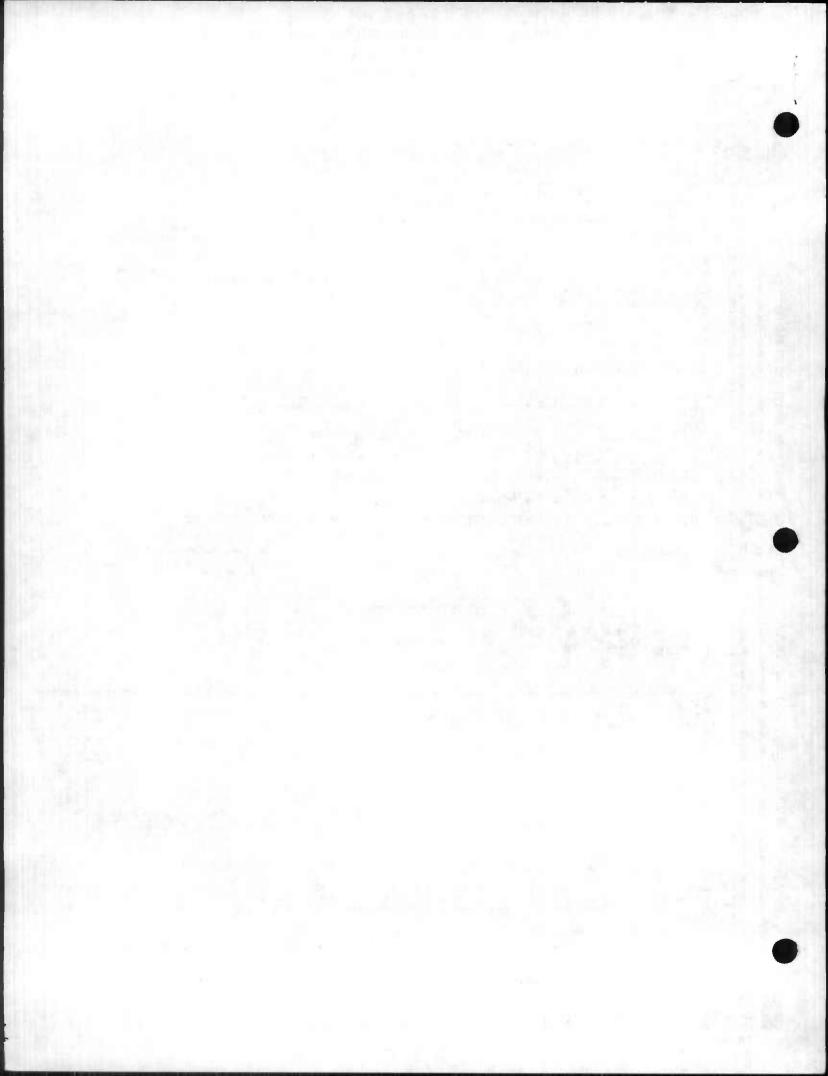
9



## Amend Item #10b, Per F.D., 11/06/2000, Carroll County, cew Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 37387

			Cer	tificate of	Death	Re	g. No.			
	1. Decedent'a Name (First, Middle, Las	0				2. Date of Death Month	Day	Year	3. Tima of Death	
Physician /Medical	Shirley Art	hur Fordyc	е			Novembe	r 2, 20	00	00:52am	
Examiner	4a Facility Nama (If not institution, giva	street and number)			4b. City, Town, or L	ocation of Death	4c. County o	of Deeth		
	Montgomery County	General Ho	spital		Olney		Mont	gome:	ry	
Funeral Director	5. Social Security Number 6. Sec 2 3 4 44 4318	x □ M 2⊠ F 7. Aga (in 7	yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Aug 29,	1929	9. Birthpl Count Wes	aca (Stata or Foreign try) t Virginia	
ž u	Usual Rasidence of Decedant  10a. Stata  10b. County. 11 COUNTY	nery 100	. City, Town or Loc	cation				10	Od. Insida City Limits	
23a or 23a-f show at be notified at al Director	MD Montgon  10e. Street and Number	ercy-	Roo	ckville		10	g. Citizen of W	hat Count	1 Yas X No	
23a or unit be rai Di	4504 Sunflower Dr	rive		208			U.S.A	•		
natural, or Items 23s Scal Examiner must sted by Funeral	11. Meritel Stetus  1 Never Merriad 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evar Armed Forces? 1 ☐ Yas 2 No If Yas, Giva Yaar or Dates:		Ves Decedent of Yes, specify Cut ☐ Yas 2☐No	Hispanic Origin? (Spoan, Maxican, Puerto Specify:	ecity Yas or No- Rican, atc.)	Black	- Amarica k, Whita, a Whit	atc.	
ygiene. Ne then 'natur nt, the Medical. Completed	15. Decedant's Ed (Specify only highest grad Elementery/Secondery (0-12)	ucation da completed) Collega (1-4or 5+)	(Give l	OO NOT use retire	during most of work ed)		6b. Kind of Bus	sinass/Ind	lustry	
Co Char		3	Н	omemaker				esti	C	
narked other marked other matic event, I	17. Father's Name (First, Middle, Last) Daniel Westfa	11 Arthur				a (First, Middla, N red Mae 1		1)		
a marra	19a. Informant's Name/Ralationship (7	ype, Print)	19b. Mailin	g Address (Stree	of end Number or Rus	ral Routa Number,	City or Town,	Stete, Zip	Code)	
27.15	Mrs. Anne Fordyce	Linn (Daug	hter) 16	398 01d	Frederick	Rd., Mt	Airy.	MD :	21771	
or other tr	20a. Mathod of Disposition  1 Burial 2 Cremetion 3	Ramovel from Stata	h Place of Discos	sition (Neme of	tion Srv.	Date 2	Oc Location - f	City or To	wn State	
partmo- portant y injury sa	4 □ Donation 5 □ Othar (Specify  21. Signatura of Funaral Sarvice License		22	Name and Addr	ass of Facility					
SEES	23a. Part1. Enter the disease, or compshock, or heart feilura. List only of	aight.	S	ykesvill	NERAL HOM e, MD 217	84 (410)-	-795-14		Approximate	
nysician Medical xaminer	Immediata Cause (Final disease or condition rasulting in death)  MASSIVE GASTROI NTESTINAL HEMORRHAGE  Dua to (or as a consequence of):  Dua to (or es a consequence of):									
physician and is the buriel-transit edical Examiner										
		d	206		1175			-		
ed by the attendir detached for use Physician/A	Part il. Other significant conditions co	ntributing to death but no	t rasulting in the un	iderlying causa g	iven in Pert I.				the cause of death'	
igned by be detac	CIRRHOIZS	of THE LI	VER			1 🗆 Ye	8 2 € No	3 Prot	sably 4 Unknow	
artificate has been signed by the attending sctor, page 2 should be detached for use.						24a. Was ar perform		ava	era autopsy findings allabla prior to mplation of cause death?	
sie has been signed by the attendir page 2 should be detached for use Completed by PhysicianA						1 □ Ya	s 2 No	10	Yas 2 No	
is certificate he director, page	25. Was casa referred to medical			15 1	26. Placa of Dee	th (Check only on	B)			
his certifi il directo	axaminar? 1 ☐ Yes 2 ♣No	Hospitai:	2 ER/Outpatien	1 3 DOA O	thar: 4 Nursing H	oma 5 Rasida	nca 6 □Otha	r (Specify	y)	
her th meral	27. Menner of Death  1  Naturel 5 Pending invastigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea		M 1[	Yes 2□No	28d. Dascribe ho			Il Route Number	
a after an Direction ed in by	4 Homicida determined	building, etc. (S)	pecify)	set, fectory, office		City or Town	, Stata)			
within 24 hours after death. To the Funeral Director: A completely filled in by the t. Medical Certificati		reician: To the best of my iner: On the basis of examination and menner stated.								
Me Within	29b. Signature end titla of certifier			29c. Licer	nsa number	25	d. Data signed	(Month,	Day, Year)	
71-0	Del J. m	st. wo		02	3630	-	Novema	ser.	2, 2000	
	30. Nama and address of person who co	mo 1622	(Item 23a) (Type, I	Print) ERICK	20 4213	GAZTHE	138486,	MA	20877	
State Registrar	31. Deta filad (Month, Day, Year)	32. Registrar's S		loa						



3	-7	0	0	0
. 1	-	9	23	25
V	-	V	U	V

					Certifica	ite of	Death		Reg. No.		
Dhamalalan	1. Decedent's Nam	ne (First, Middle, La	ist)	MILET				2. Date of Month	Deeth Day	Year	3. Time of Death
Physician /Medical	FRED	FRANCIS	FARVER					Novem	ber 03,	2000	8:12 P.
Examiner	4a Facility Name (	If not institution, giv	e street end number;				4b. City, Town	, or Location of De	eth 4c. Cou	nty of Deeth	
			orial Ho				Fred	erick Hrs. 8 Dete of		reder	
uneral	5. Social Security N		Sex 7. Ag	ge (In yrs. last bii	Month	er 1 Year s Days			Birth 1925	9. Birth	place (State or Foreigntry)
irector	Usual Residence o	2737		75	Yrs.			1 6 3	16 192	5	MD
ž	10a. Stete	10b. County		10c. City, Tow	n or Location						10d. Inside City Limit
or selection	MD										1 X Yes 2 □ N
be notified Director	MD 10e, Street and Nu	Carro	011	Tar	leytow	n Ip Code			10g. Citizen	of What Cou	intry?
23e or 28e-f show can be notified at rai Director		cond St	woo+				707				
iner sunt Funeral	11. Marital Stetus	cond bt.	12. Was Decedent	Ever in U.S.	13. Was Dec		L787 Hispanic Origin	? (Specify Yes or	US No- 14. F	A. laca - Ameri	ican Indian,
iner in		ried 2 Married	Armed Forces	701.2				? (Specify Yes or Puerto Rican, etc.)	E	leck, White	
0 🗎 🕒	3 Widowed		If Yes, Give Year or Dates:	1945	1 🗆 Yes	2 □ No	Specify:		Spe	city: Wh	nite
"natural", edical Ex		15. Decedent's E	ducation	16e	Decedent's Us	uel Occu	petion		16b. Kind o	Business/Ir	ndustry
	Elementery/Seco	cify only highest gre	ede completed) College (1-4or	54)	(Give kind of v	use retire	during most of ed)	f working	Mt.	St. M	fary's
ont, the Man	7	oridory (o 12)	College (1 40)	3+)	Elec	tric	ian		Coll	ege	
55 6	17. Father's Name	(First, Middle, Last	)				18. Mother's	Name (First, Mide	dle, Meiden Sun	eme)	
arked o	Harry (	O. Farve	er				Mar	tha Sny	der		
r la me traume	19e. Informant's N	eme/Reletionship (	Type, Print)	196	. Meiling Addre	ss (Stree		or Rurel Route Nur		vn, Stete, Zi	ip Code)
7.3	Jerry Fa	arver/so	on	22	220-A	Blue	bird I	Or. Wes	tminst	er. M	ID 21157
item 2 other	20e. Method of Dis	position		20b. Plece o	Disposition (A	leme of	ace)	Dete	20c. Location	n - City or T	ID 21157 Town, Stele
# 7 F		☐ Cremation 3 L 5 ☐ Other (Special	Removel from State  (y)		ny Cer			11/7	Tayl	orsvi	lle, MD
Important: If ite any injury or of once.	21. Signeture of Fu	neral Service Lice	need		22. Name	and Addr	ess of Fecility				
E S S	1	KN	/-					Home 8			MD 21157
	23a. Pert1. Enter	the disease, or com	plications that cause	d the deeth. Do						,	Approximete
sician	shock, or hea	art fellure. List only	one ceuse on each I	ne.						t	Onset and Death
edical	Immediate Cause		assis	this.	- 10 01 - 102					1	1 day
miner	disease or condition resulting in deeth)	on	a. 00 p17	Due to (or as e	onemone						
je l	The William			000 10 (01 000 0	01/0	.,.				1	710110
physician and s the burial-transit sdicai Examiner	Sequentially list or	anditions.	b	Due to (or es a	consequenca o	f):					710 yrs 710 yrs
EX EX	Sequentially list co if eny, leading to in cause. Enter Under Cause (Disease or	nmediete erlying			AIN						>10 m
physicia ss the bur edicai	Cause (Disease or thet initiated events resulting in death)	5	C	Due to (or as a	consequence of	f):			-		
0 0	resulting in death)	Last			CAY	)					710 yrs
endir r use			d		Criz					1	
ed by the attendin detached for use detached for use	Part II. Other signit	ficant conditions of	contributing to death t	out not resulting i	n the underlying	cause g	iven in Pert I.	23b. D	ld tobacco use	contribute	to the cause of deat
by the								1	Y Y 2 2 N	0 3 Pr	obably 4 Unkno
7 4											
5.2									es en eutopsy erformed?	a	Vere autopsy finding vailable prior to
5 2										C	ompletion of cause of deeth?
5 2									\ /	1	☐Yes 2☐No
has been sign ge 2 should be mpleted by								. 1	Yes 2 N		
has been sign ge 2 should be mpleted by	25. Wes case refer	rred to medical					26. Plece o		~		
s certificate has been sign director, page 2 should be o Be Completed by	25. Wes case referexaminer?		Hospitel: 1 Inpati	ent 2 ER/Ou	rtpatient 3□	DOA O	ther	Deeth (Check on Ing Home 5 R	ly one)		ify)
his certificate has been sign al director, page 2 should be To Be Completed by	examiner? 1  Yes 2 2	No th	28a. Dete of Inju	iry 28b.	Time of	28c. Inju	ther: 4 Nursi	Deeth (Check on ing Home 5 R	ly one)	Other (Spec	ify)
his certificate has been sign al director, page 2 should be To Be Completed by	examiner?	No	28a. Dete of Inju	iry 28b.		28c. Inju	ther: 4 🗆 Nursi	Deeth (Check on ing Home 5 Re 28d. Descrit	ly one)	Other (Spec	ify)
rr: After this certificate has been sign to funeral director, page 2 should be tuneral director. Page 2 should be attorn: To Be Completed by	examiner? 1 Yes 2 2  27. Menner of Deet 1 Naturel 2 Accident 3 Suicide	No th 5 ☐ Pending	28a. Dete of Inju (Month, De	iry Year) 28b. i	Time of njury M	28c. Inju W	ther: 4 Nursi ury at ork? Yes 2 No	Deeth (Check on ing Home 5 R. 28d. Descrit	esidence 8 De how injury oc	Other (Spec	rel Route Number,
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rr: After this certificate has been sign to funeral director, page 2 should be tuneral director. Page 2 should be attorn: To Be Completed by	examiner? 1  Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	5 Pending investigetio 6 Could not be determined	28a. Dete of Inju. (Month, De 28e. Pleca of Inbuilding, el 28e. To the best ininer: On the basis of the basis	iny Year) 28b. jury - At home, fe c. (Specify) of my knowledge f examination an	Fime of njury M  orm, street, fect- o, deeth occurred/or investigation	28c. Inju Winter 1 [ only, office and et the 1 only, in my	ther: 4 Nursi	Deeth (Check on ing Home 5 R R 28d. Descrit	esidence 8 De how injury och (Street end No Town, Stete)	Other (Specicured	rei Route Number, stated. to the cause(s)
Funeral Director: After this certificate has been sign stay filled in by the funeral director, page 2 should be dical Certification: To Be Completed by	examiner?  1 Yes 2 X  27. Menger of Deel  1 Naturel  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)	5 Pending investigetio 6 Could not be determined	28a. Dete of Inju. (Month, De 28e. Pleca of Inbuilding, el 28e. To the best ininer: On the basis of the basis	iny Year) 28b. jury - At home, fe c. (Specify) of my knowledge f examination an	Fime of njury M  orm, street, fect- o, deeth occurred/or investigation	28c. Inju Windows of the top, in my	ther: 4 Nursi vy at ork? Yes 2 No noime, date end i opinion, deeth	Deeth (Check on ing Home 5 R R 28d. Descrit	esidence 8 De how injury och (Street end No Town, State)  the ceuse(s) end en, date end ple	Other (Specicured	rei Route Number, stated. to the cause(s)
rr: After this certificate has been sign to funeral director, page 2 should be tuneral director. Page 2 should be attorn: To Be Completed by	examiner? 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	h  5 Pending investigetio 6 Could not be determined  Certifying Pt 2 Medical Exar  title of certifier	28a. Dete of Inju. (Month, De 28e. Pleca of Inbuilding, el 28e. To the best ininer: On the basis of the basis	iny y Year) 28b. in y Year) 28	Firme of njury M M  orm, street, fect o, deeth occurre d/or investigation	28c. Inju William 1 Coory, office and et the toon, in my 29c. Licer	ther: 4 Nursi ont? Yes 2 No	Deeth (Check on ing Home 5 R 28d. Descrit	esidence 8 De how injury och (Street end No Town, State)  the ceuse(s) end en, date end ple	Other (Specicured	rei Route Number, stated. to the cause(s)
To the Funeral Director: After this certificate has been sign complately filled in by the funeral director, page 2 should be Medical Certification: To Be Completed by	examiner? 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	S Pending investigation 6 Could not be determined.  Certifying Pt 2 Medical Examination 1 title of certifier ress of person who	28a. Dete of Injuided in the I	iny y Year) 28b. jury - At home, fec. (Specify) of my knowledge f examination an eted.	Firme of njury M M  orm, street, fect o, deeth occurre d/or investigation  (Type, Print)	28c. Injunction of the form of	ther: 4 Nursi  Ny at ork?  Yes 2 No   Deeth (Check on ing Home 5 R. 28d. Descrit  28d. Descrit  28f. Location City or occurred et the time	by one) esidence 8 □ be how injury oc on (Street end No Town, State) the ceuse(s) end ne, date end ple	Other (Specicured Imperor Rumber or Rumber or Rumber of	rei Route Number, stated. to the cause(s)	

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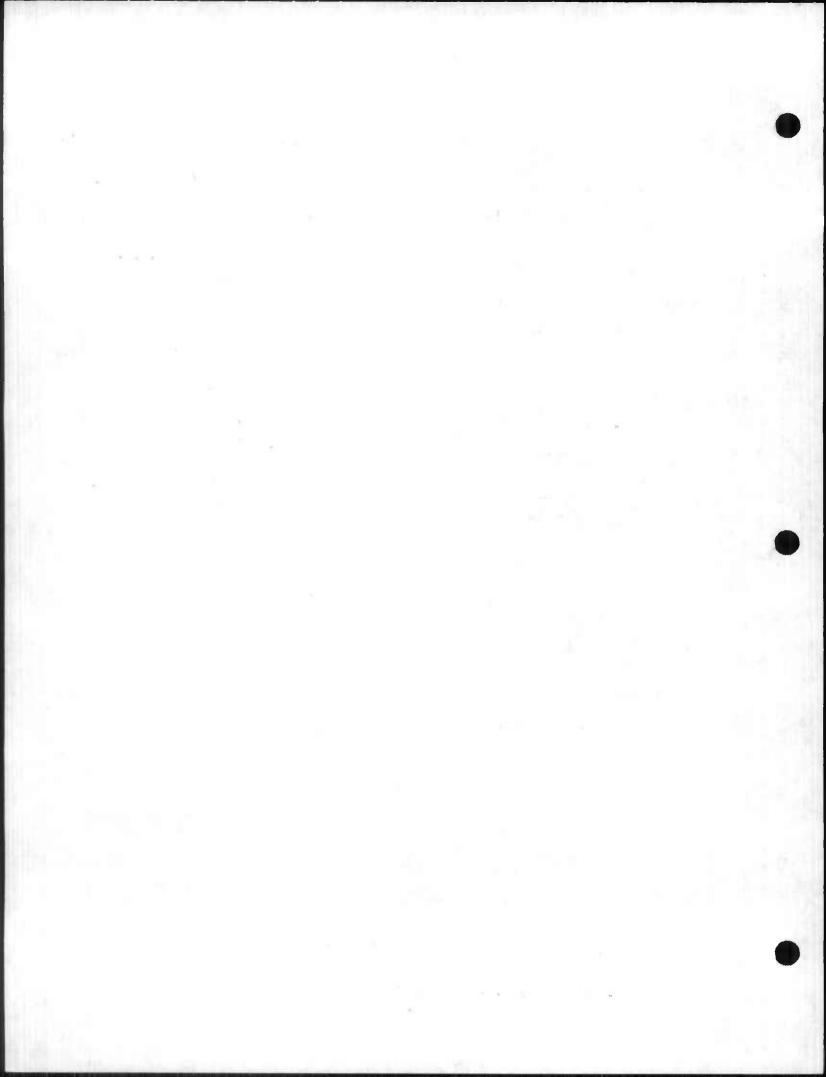
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## Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 37389

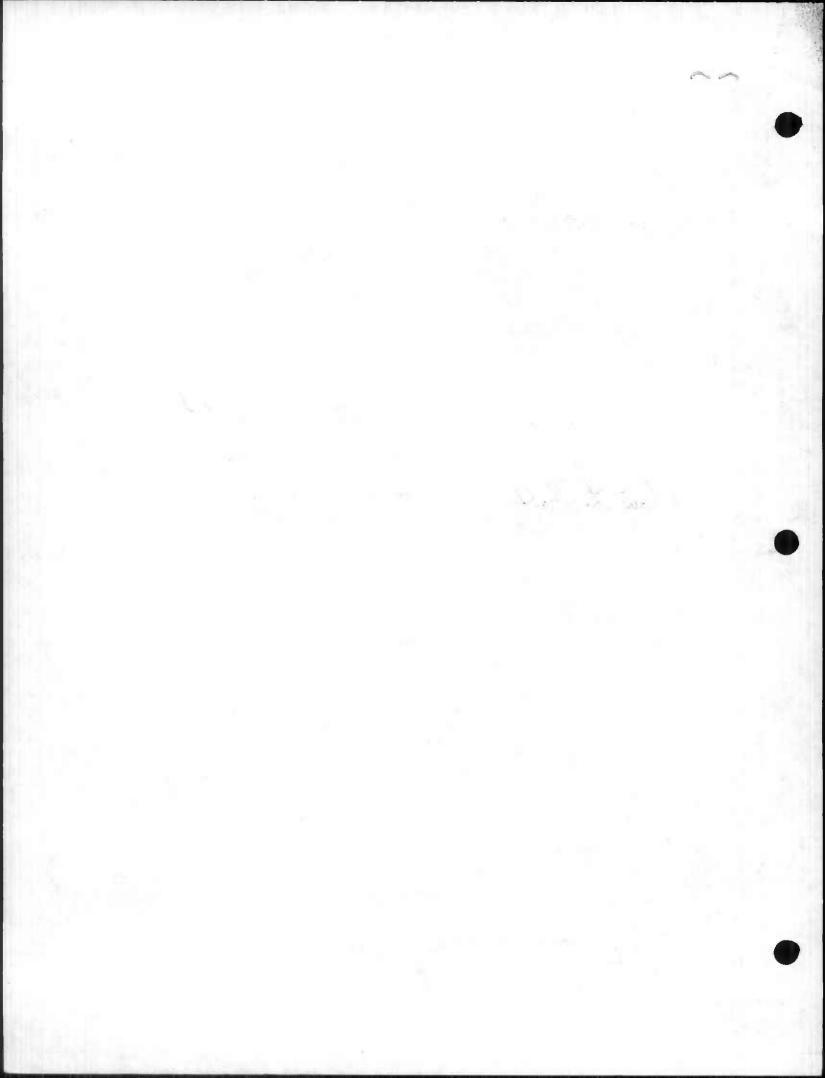
Certificate of Death

			Ce	lllica	C UI	Death			Reg. No.			
Physician /Medical	Decedent's Nama (First, Middla, La Flora  I	Marie	Gray					2. Date of De Month Octobe	r 28, 2		3. Time of 8 : 0	Death
Examiner	4a Facility Name (If not institution, gives		al				m, or Lo	ocation of Deat		y of Death Ce Geo	orge's	5
Funeral Director	5. Social Security Number 6. 5 579–30–9452		n yrs. last birthday,	If Unda Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da June 2	9,1928	9. Birthpl Count	lace (Stete of	or Foreign
f show lind at for	Usual Residence of Decedent  10a. Stata 10b. County  Maryland Prince	George's	Dc. City, Town or L FOI	ocation t Was	shin	gton				16	0d. fnside C	
or 28e-f's be notified Director	10e. Street and Number			10f. Zi	p Code				10g. Citizen of	What Coun	try?	
23a cast by	7306 Allentown	Road			2074	4			U.	S.A.		
ar, or flams 23a or 28e-f shore Examinar must be notified at by Funeral Director	11. Marital Status  1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedent Eva Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates:	r in U,S. 13.	Was Dece If Yes, spe 1 Yes		dispanic Orig an, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	Speci	ce - Amarica ck, White, of fy:		
ygiens, neturn ser than "neturn t, the Medical. Completed	15. Decedent's E	ducation	16a. Dece	dent's Usu	ial Occup	pation during most d)	of work	ina	16b. Kind of E	Business/Ind	dustry	
mple plan	Elementary/Secondary (0-12)	College (1-4or 5+)				d)			ന ി ര	nhone	Compa	ans,
	8th 17. Fathar's Name (First, Middle, Last	N/A	O <u>r</u>	erat	or	18 Mothe	r's Nam	e (First Middle	, Meiden Sume	_	Compe	міу
Montal H srked ott stic ever To Be	THE PROPERTY AND PROPERTY OF STREET	llosi				TO. WOUTE	Ev					
ath and 27 is ma or trauma	19a. Informant's Neme/Reletionship ( Nathan H. Gray (		19b. Mail 73(	ing Addres 06 Al	s (Stree lent	end Numbe OWN Ro	or or Aur oad	Ft. Was	er, City or Town hington	, Stete, Zip Mary	Code) land 2	2074
unt: If them ary or oth	20a. Mathod of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State	20b. Place of Disp cematery, cre Resuri	metory or	other ple	00)	1	2 <b>20</b> 00	20c. Location		wn, Stata arylai	nd
Departs imports any inji	21. Signature of Funeral Servica Uce	A CONTRACTOR				ess of Facilit Alexar	1		ral Hom			2073
Medical Maminer	Immediate Cause (Final disease or condition resulting in death)	Du	hylococol	quenca of	):					1	3 Wed	eks
nding physician and use as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Du C.	ebral Os	quenca of	):	115			7			
d for u	Part II. Other significant conditions	contributing to death but n	ot resulting in the	undertvina	cause di	ven in Pert I		23b. Did	tobacco uee c	ontribute to	the cause	of deati
signed by the atter d be detached for u d by Physiciar		ellitus, Pne							Yes 2 XNo		bably 4□	
shoul									s an autopsy ormed?	av	ere autopsy ailable prior mplation of death?	cause
page 2								10	Yes ZHNo	10	Yes 2	I/A No
certificate irector, par	25. Wes case referred to medical examiner?	142-1					of Dee	th (Check only	one)			
T digital	1 ☐ Yes 2 ☑ No 27. Menner of Death	Hospitel:	2 ER/Outpatie		UA		irsing Ho		how injury occu		ý)	
rs after death. al Director: After t led in by the funer: Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not 8	28e. Placa of Injury	- At home, farm, s	М		rk? Yes 2	No	28f. Location	(Street end Num		el Route Nur	mber,
n 24 hours afte ne Funeral Dir pletely filled in edical Cerl	29a. Certifier 157 Certifying Ph	building, etc. (	ny knowledge, dee					and due to the	cause(s) end n			(-)
the Funerant Peter fill the Funerant Peter fill the Funerant Peter fill the Funerant Peter Funer	(Check only 2 Medical Examone)	miner: On the basis of ex and mannar stated		ivestigatio	n, in my	opinion, dea	th occur	red at the time				(S)
Total	29b. Signature and title of hertilier	Sloe	S	D		9633			29d. Date sign			
(1)/	30. Name and address of person who	completed cause of deat	h (Item 23a) (Type 7501 Sui			- 1100		a7 ' 1	Manual	1.0	0005	



						Certific	ate of	Death	F	leg. No.		
		1. Decedent's Nama (Fir	st, Middle, La	st)					2. Data of Dea Month		Year	3. Time of Death
40%	Physician /Medical	Evelyn	L. Gar	rison					October		000	4:18PM
	Examiner	4a Facility Nama (If not						4b. City, Town, or L			W - W	
		Bradford	Oplea No	araina Hom	_			Clinton		Prince	e Geo	orge's
	Funeral	5. Social Security Number			e (In yrs. last bii	thday) If Un	der 1 Year	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Dey June 1	( Year)	9 Birthol	eca (State or Foreign
н	Director	579 09 1015	1	□м 21Д F	89	Yrs.	Doys	Tiours Itimi.	June 1	, 1911	Vir	ginia
Т	p ,	Usual Residence of Dac			10a City Tay	n or Legation					11	Od Incide City Limits
	ehov chov		County	N	10c. City, Tow	Washi	naton				10	0d. Inside City Limits 1 ☐ Yas 2 ☐ No
	or 28-f	Maryland P	rince (	George's	FOLC							
	vith t	10e. Street and Number 9004 Pine	huret	Drive		101.	Zip Coda	0744	300	10g. Citizen of Wi		
	n 72 hours after death with the Maryland *natural*, or items 23s or 28s-f show solds Eventure must be notified at	9004 F.H.	iurse .	12. Was Decedent I	Cupa in 11 C	12 Mac Da		0744	positu Voc or No	United 1		
	Hem Hem	11. Marital Status	2 Marriad	Armed Forces?		If Yes, s	specify Cub	Hispanic Origin? (Spen, Maxicen, Puerto	Ricen, etc.)	Black	, Whita, a	
20	urs aff	3 □ Widowed 4 □X		1 ☐ Yas 21万0 If Yes, Give Year or Detes;	10	1 ☐ Yes	2 XXVIO	Specify:		Specify:	Whi	te
21215-0020	tura stura	15.	Decedent's Ed		16a	. Decedent's L	Isual Occur	pation		16b. Kind of Bus		
15	n n n	(Specify or	nly highest gra	ide completed)		life. DO NO	T use retire	during most of world)	ding			
21	a filed within all Hygiene. other than " rent, the He	Elementery/Secondery	y (0-12)	College (1-4or 5 N/A	(*)	Supervi	sor			Credit	Bur	eau
	be filed within 72 ho ttal Hygiene. d other than "naturi event, the Medical Be Completed	17. Father's Name (First						18. Mother's Nam	e (First, Middla,	Maiden Sumeme	)	
lai		Edward Do	offlemy	er				Carrie K	ibler			
Maryland	2 should and Men le marke eumatic	19a. informant's Neme/i	Relationship (	Type, Print)				t end Number or Ru				
	and 2 n 27 in 27 in er tr	Norman Garr	rison (	SON)	90	004 Pin	ehurs	st Drive,	Fort Wa	shington	, MD	20744
altimore,	of Hez	20e. Method of Disposition		Removal from State	20b. Plece o cemete	f Disposition ( ry, cremetory	Neme of or other ple	oce)	Date	20c. Location - C		
Ĕ	Pages nent of ant: If its ury or o	4 Donation 5			Cedar	Hill C	emete	ery Nov 4		Suitland		
at	permit. Pages 1 and 2 should Department of Health and Mer Important: If tem 27 is marke eny injury or other treumatic once.	21. Signatury Funerel	Service Licer	1590		22. Name	and Addra	ass of Facility Let	Funera	I Home, I	nc 6	633 Old
0	897 2 8	Dous	X. 18	rant		Alexa	ndria	Ferry Ro	oad, Cli	nton, Ma	ryla	nd 20/35
		23a. Part1. Enter tha dis shock, or heart feil	seasa, or com	plicetions that ceused	tha death. Do	not anter the r	node of dyi	ng, such es cardiac	or raspiretory er	rest,	1	Approximate interval Between
η	Physician											Onset and Death
	/Medical	Immediata Cause (Final disease or condition		HRUZZI	25018	DITC	A	WOVAS	CURAL	SZILL	32	48425
В	Examiner	resulting in deeth)		6.	Due to (or es s							
-	R = 0			b								
	and tran	Sequentially list condition	ins,		Dua to (or as a	consequence	of):					
60,	clan clan	Sequentially list condition if any, leading to Immed cause. Enter Underlying Ceuse (Disease or injury that initiated avants	ata	C							1	
68760,	ifficate be associted graysiclan and as the bunal-transit	that initiated avants resulting in death) Last			Dua to (or as a	consequence	of):					
-	= 000		- 6	d								
Box	ires that the deeth cert signed by the attendin d be detached for use d by Physician/N											
P.O.	0 0 0 -	Part II. Other significant	conditions o	ontributing to death be	ut not resulting I	n the underlyir	ng cause gi	ven in Pert I.				the cause of death?
	ed by deta				3000				10'	rss 225 No	3 Prob	bably 4 Unknown
Sp	requires that the een signed by the hould be detache etech etech etech by Phys								24e. Was	en eutopsy	24b. We	ere autopsy findings
Ö	been si should leted								perfo	rmed?	cor	mileble prior to mpletion of ceuse
Records,	2 2 8											deeth?
	icate h								101		1 [	Yes 2 No
Viitai	Physicien: The lav rbis certificate has ral director, page 2	25. Was cese referred to examiner?	medice!	Hospitel:			Ot	26. Place of Dea				
ō	this ald	1 Yes 2 No		1 L inpatie		utpatient 3  Time of	DOA	4 pp Nursing H	-	lence 6 Othe		1)
5	After fune	1 Neturel 5	Pending investigation	28a. Dete of Inju (Month, De)	Year)	Injury	28c. inju	rk? ]Yes 2□No	200. 2000/100 1	ion injury cocurre		
S	death ctor: A the f	2 Accident 3 Suicide 6	Could not be		Inv - At home fe			, , , , , , , , , , , , , , , , , , , ,	28f. Location (5	Street end Numbe	r or Rure	il Route Number.
Division	tal or Attending P rs after death.  al Director: After t led in by the funers Certification:	4 Homicide	determined	building, etc	(Specify)	, , , , , , , , , , , , , , , , , , ,	nory, omoo		City or Tow			
_	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification	29e. Certifier 18	Certifying Ph	ysician: To the best of	ot my knowledge	e, death occur	red at the ti	me, date and place	end due to the	ceuse(s) end mar	iner es st	ated.
	in 24 hour in 24 hour he Funera pletely fill.	(Check only 2 one)		niner: On the basis of and manner ste	examinetion en							
	New think	29b. Signature end title	of certifier				29c. Licen	se number		29d. Dete signed	(Month, I	Dey, Year)
	11	1 11	25		M	- 4-4	D-	1854	5 1	DUFURS	ER	1, 2000
	(0)	30. Neme and eddress of	f person who	completed ceuse of d	eeth (Item 23a)	(Type, Print)	V	(00)		J		
		Philip W					ingto	n Rd. #40	5 Ft. W	ashinato	n, M	d.
	State	31. Date filed (Month, Da	ay, Year)		ar's Signature							
	Registrar		100	Sener	6	100 14						

DHMH 16 Rev 6/95



00-6323-033 Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. UNKOWN 00-315 SAUNDRA AMENDED ITEM# 28d per ME G792 030101 SS amend item 23a, 27, 28a, bc, d, ef, per me contincate of peath 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** NOVEMBER 08, 2000 03:45 A.M. Saundra Patricia Grigsby /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE 's OXON HILL INNER LOOP 1495 west of ROUTE 210 If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplace (Steta or Foraign Country) **Funeral** 1□M 20 F Months Days Hours Yrs. 577-94-7052 Dec. 6, 1968 Washington, D.C Director 31 Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 28a-f show r than "natural", or items 23s or 28s-f ahor the Medical Examiner must be notified at 1 X Yas 2 No Directo Prince Georges Suitland 10g. Citizen of What Country? 10s. Street and Number 10f. Zip Coda 3310 Curtis Drive #20 20746 USA Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian. 11. Maritai Status Black, Whita, atc. e filed within 72 hours after al Hygiene. other than "natural", or ite 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify P 3 Widowed 4 Divorced Black Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry America Elementery/Secondary (0-12) Collega (1-4or 5+) 12th Correctional Officer Correction Corp of permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any Injury or other traumatic event phose. 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middla, Last) Be Linwood Grigsby Edith Carter 19b. Meiling Addrass (Straat and Number or Rurel Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Edith Grigsby - Mother 12 Florida Ave. N.E. Washington, DC 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Rock Creek Cemetery 11-14-00 Washington, D.C. 22. Nama and Address of Fecility
Marshall's Funeral Home, Inc. no of Funeral Sarvice Licensee 46 4217 9th St. NW. Washignton, DC 20011 23a 16.1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) ACUTE THERMAL INJURY OF AIRWAY Examiner Dua to (or as a consequence of) Examiner certificate be executed Sequentially list conditions, if any, laading to immadiata ceuse. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) and physician Box 68760 Physician/Medical Dua to (or as a consequence of): the attending 980 0 P.O. 1 23b. Did tobacco use contribute to the cause of death? Part ft. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. been signed by the should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 17 Unknown þ Records, 24b. Wara autopsy findings availabla prior to complation of ceusa of daath? 24a. Was an autopsy performed? Be Completed pege 2 2 No Pes 2□ No certificate of Vitai Physician: 25. Was cese referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Nother (Specify) SCENE To 1 ¥ Yes 2 □ No this 28d. Dascribe how injury occurred motor vehicular accident motor vehicle collision and enicle subsequently caught on fire 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury Certification: Injury at Work? After A Division or Attending 5 Pending invastigation 1 Natural after deeth.

Director: Aft
d in by the fur М 1 ☐ Yas 2 ☑ No 11/8/00 2:35 2 Accidant 6 Could not be detarmined 28f. Location (Street and Number or Rural Royta Number, City or Town, State) I-495 at 210, Oxon Hil 3 Suicida Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 2 4 Homicide Md. Interstate within 24 hours a To the Hospital edicai 29a. Certifier 1 Certifying Physician: To tha best of my knowledga, death occurrad at tha tima, data and placa, end dua to the cause(s) and mannar es stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and NOVEMBER 08,2000 O.C.M.E. no ceusa of death (nem 23e) (Type, Print) 30. Nama and addrass of person who compl

Registrar **DHMH 16 Ray 6/95** 

State

**ORIGINAL** 

111 Penn Street, Baltimore, Maryland 21201

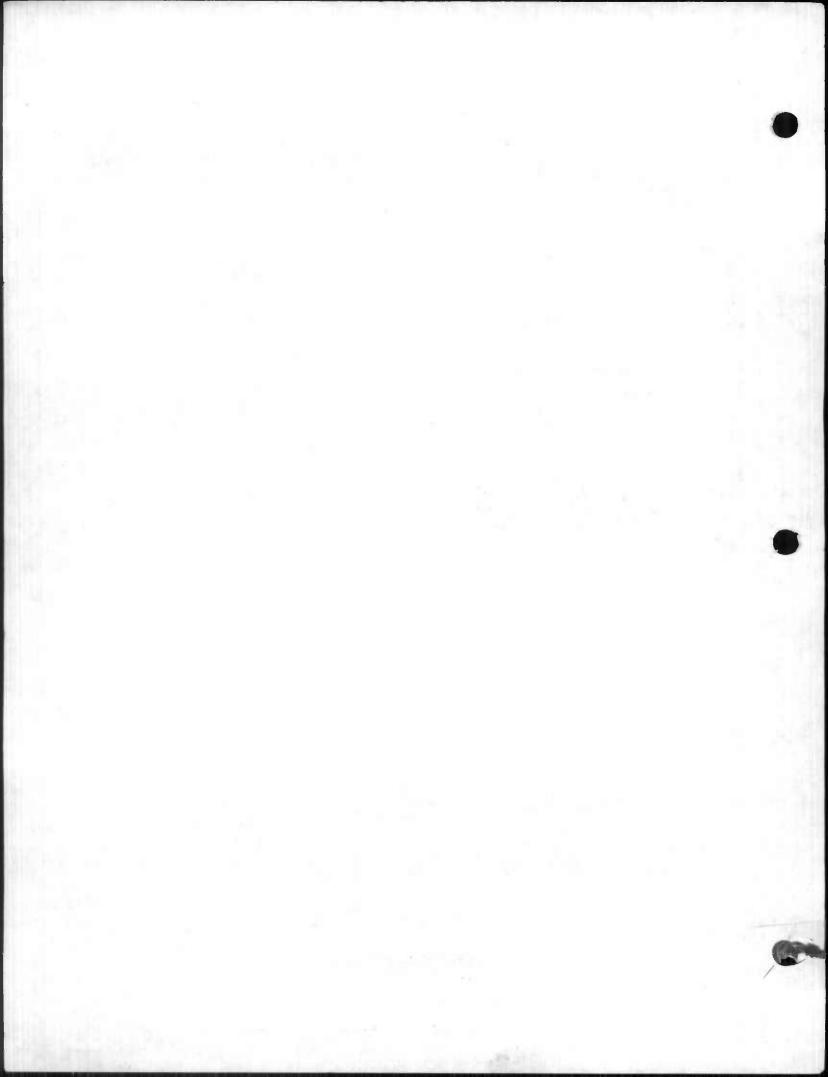
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32. Registrar's Signatura

TIEVOURE ed (Month, Day, Year)

1 6 2000

MOA



00-6132-033 jhm DE GA

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

BRA JUNE RDENER			Otate of	Maryiai		tificate of	Death		Reg. No.	0 3	1392			
Physiciar /Medica	Decedent's Name (First, Middle, Last)     DEBRA JUNE GARDNER							2. Dete of Dee Month OCTOBE	Dey Year		3. Time of Death			
Examine	4a Facility Name	(If not institution, giv		nber)			4b. City, Town, or Lo BOWIE	or Location of Death 4c. County of Death						
Funeral Director	12118 5. Social Security 212-68-	E LANE Sex	7. Age (In yrs. last birthday) If Under 1				8. Date of Birth (Month, Day AUG. 3, 1			EORGES  Inplace (State or Foreign untry)  h. D.C.				
	Usuel Residence			10.0	-			110015,1						
show show	10a. State 10b. County 10c. City, Town or Location 10c. Ci								10d. Inside City Limits 1%□ Yes 2 □ No					
ifer death with the Meryland riters 23e or 28e-f show other roughly incoming the morning at	10e. Street and N 12118 I		1	10g. Citizen of What Country? U.S.A.										
or its		rried 2 Married	Armed For 1 Yes If Yes, Giv	. Was Decedent Ever in U.S. Armed Forces? 1 _ Yes _ 2\overline{V} No if Yes, Give ** Year or Dates:		13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2♥ No Specify:			14. Rac Blac Specify	e - American Indien, ck, White, etc.				
od within 72 hours at sygiene.  For the "natural", or it, the first from the formula for the f	(So	15. Decedent's E-	ducation ade completed)		(Give	lent's Usual Occup	during most of work	ing	16b. Kind of Business/Industry					
2121 d within giene.	Elementary/Sec		Coilege (1	-4or 5+)	life. L	OO NOT use retire	d)							
d 2 d Hilled A Hilled		e (First, Middle, Last	4		RETAL	RETAIL SALES  18. Mother's Na			Maiden Suman	IL- BOOKSTORE				
should be filed and Mentel Hygi marked other imatic avant,	MARSHAL	L C. G	ARDNER				JUNE	A. HA	ALLER					
10		Name/Relationship (	Type, Print)				and Number or Rur				ode)			
C = 8 5		GARDNER/ B	ROTHER	look			ON ST., A				Chale			
nord History or out		2√Cremetion 3 □		State HI	cemetery, cren JNTT CR	sition (Neme of natory or other pla EMATORY	(ce)	.3,2000	WALDOR		, State			
Baltimore, semit. Pages 1 a Seperiment of He mportant: If itsm mortant or othe		1 1 5 ☐ Other (Special Funerel/Service Lice	**		22	Name and Addre	ess of Facility							
Ba Perm Deperment	NP 4	10	2 3	/	RO	BERT E.	EVANS FUN			C. 1600	00			
	23a, Partt, Enter	the disease, or coment failure. List only	plications that or	aused the dee			RD., BOW			A	oproximate tervel Between			
Physician /Medical Examiner	Immediate Cause disease or condit resulting in death	e (Final	a	Luc,	he or as a consequence	Polet	1 + Z	0		0	nset and Death			
D = 5				00010 (	or as a conseq	delice dij.			0					
cate be executed physician and sthe buriel-transit	Sequentially list of	conditions,	D	Due to (	or as a conseq	uence of):					11/4/2			
		derlying or injury	c											
W = 72	resuring in death) List													
P.O. BOX (hat the death certified by the attending leteched for use a physical and the standard for the stan		_	d											
O. Bo	Part II. Other sign	aificant conditions	ontributing to de	ath but not re	sulting in the ur	nderlying cause gi	ven in Part I.	23b. Did tobacco use contribute to the cause of death						
								101	Yes 2□ No	3 Probat	oly 4 Unknow			
ew requires been a 2 should									24a. Wes en eutopsy performed?  24b. Were autop: evailable pri completion oil death?					
								12	res 2□No	10	'es 2□ No			
Vita	25. Was case reference?		Hospital:			0	26. Place of Deal							
Physic physic rithis or rithis or rithing or right.			28a. Date of	•	ER/Outpatien	T JU DOA	DOA Other: 4 Nursing Home 5 Residence 8 Souther (Specify)  28c. Injury at Work?  28d. Describe how injury occurred							
Division of standing P is after death.  al Director: After ted in by the funer control of the	1 Natural	1 Yes 2 De Subject with helin hon												
Division or Attending after death. Director: After Jin by the fune	3 ☐ Suicide 4 ☐ Homicide	6 Could not b	200. Place	of Injury - At I	nome, farm, str	eet, factory, office		28f. Location (Street and Number or Rural Route Number,						
Div Lal or A safter ai Dirac		4 Homicide building, etc. (Specify) home							City or Town, Stete) 12/18 Lingrich					
hound in the series	29a. Certifier (Check only one)	1 Certifying Pt 2 Medical Exar	niner: On the ba	sis of examina	owledge, death ation and/or inv	occurred at the ti restigation, in my	ime, date and place, opinion, death occur	and due to the cred at the time,	cause(s) and m date and place,	anner as state and due to th	ed. ne cause(s)			
To the Ho within 24 To the Fu complete		d little of certifier	and mann	IDI SIBIDO.		29c. Licen	se number		29d. Date signe	ed (Month, Da	y, Year)			
F3E8	1 The L. 11 1.					oc	ME		OCTOBER 28, 2000					
(4)	30. Name and add	dress of person who	completed caus	e of death (Ne	m 23a) (Type.	Print)		1						
()/		EDDORE 1		U	111 P	enn Stre	et, Balti	more, Ma	aryland	21201				

State Registrar THE ON ORE M. K.

31. Date filed (Month, Day, Year)

NOV 0 6 2000

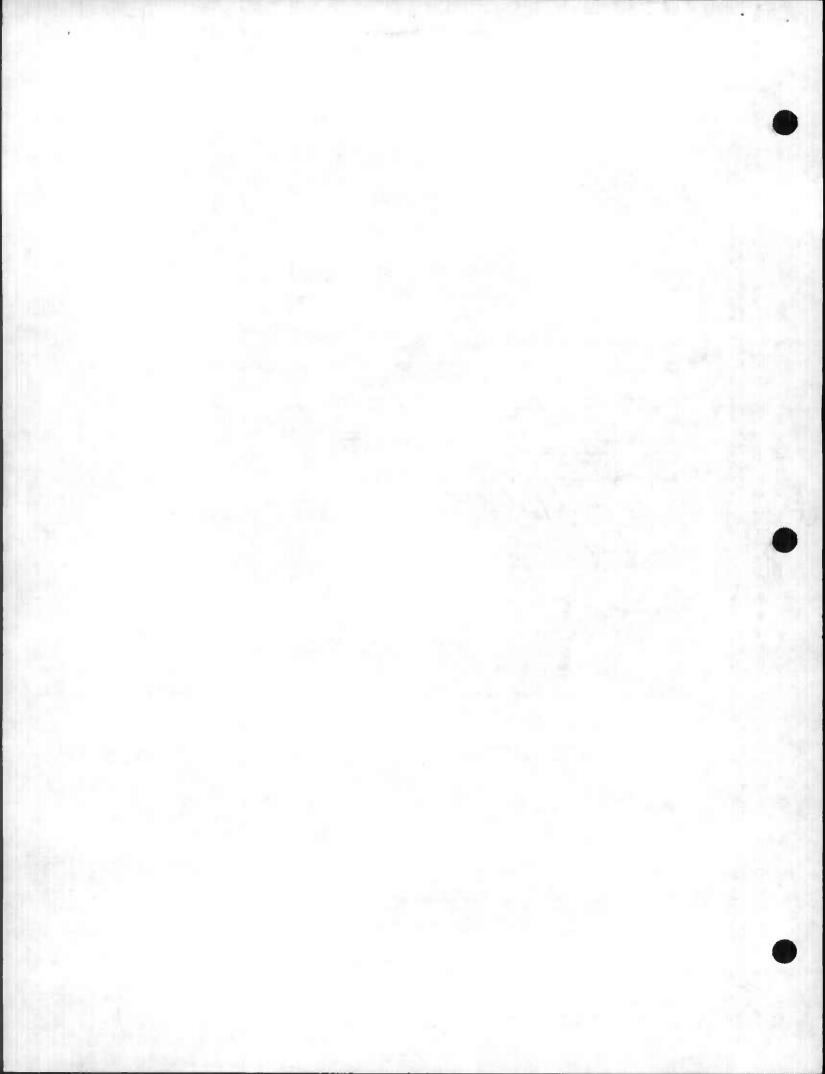
Registrer's Signeture

Richard Glessmann

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Moderation   A Facility Name (If not institution, pive street and number)   University of Merry land Medical Center   Ab City, Town, or Location of Accounty of Deen   N/A	Physician	1. Decedent's Name (First, Middle, Last)  Richard Glessmann								Reg. No.  2. Date of Death Month Day Y			3. Tima of Death
Date	Medical	4a Facility Neme (If not institution, give street and number)							or Loca	tion of Death 4c. Cou		of Death	1:15 P.I
The Steam of the Country Control of the Steam of the Country C		054-48-5736							Hrs. 8	Date of Birth (Month, Day 8 - 18 -	1961	9. Birthpi Coun Phil	lace (State or Foreig try) .a Pa.
1.1 Merital Status   1.1 Mer	50	10a. Stata 10b. County	stcheste		Town or Lo		Pelh	am M	ano	r		10	0d. Inside City Limit:
11. Merital Status   12. Wes Depodent   Event   1.5.   13. Wes Decodent of Hispanic Copyn (Specify Vas or No-mirror Name (Prince Name Copyn   1.   12.   12.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   13.   1	I Direct		Place					3					
To Develop only Project grade completed   To College (1-for 5)   To College (1-for 5)   To College (1-for 5)   To College (1-for 5)   To Develop only Project grade completed   To College (1-for 5)   To Develop only Project Grade (1-for 5)   To Develop only To College (1-for 5)   To Develo		1 Never Married 2/17/Merrie	es?	J-No 3				? (Specif uerto Ric	y Yes or No- can, etc.)	Bleck, White, etc.			
17. Father's Name (Prior), Microsis, Last)   19. Mailing Address (Sireer and Number or Rural Route Number), City or Town, State, Zip Code)   19. Mailing Address (Sireer and Number or Rural Route Number), City or Town, State, Zip Code)   12.3 E., 8.2 nd St. New York NY 10028   20. Location of Disposition   10. Line of Dispositi		(Specify only highest	grade completed) College (1-4	40r 5+)									
198. Informant's Name/Relationship (Type, Phint)   190. Malling Address (Street and Number of Plural Route Number, City or Town, State, 12 Code)   123 E. 82 nd St New York NY 10028   200. Which of Disposition   10 Burial 2 (Screentian) 3   Removel from State 4   Donation 5 (Dother (Specify)   10 Dote (Specify)   12 Dote (S	Be	17. Father's Name (First, Middle, Last)  18. Mother's Neme (First, Middle, Maiden Sumame)  Figure 17. Father's Name (First, Middle, Maiden Sumame)									,	0	
Committee   Comm		Amanda El			123	E.82	2nd		ew :	York	NY 100	28	
23a. Pert : Entire the bissesse. opcomplications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximate and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximate and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximate and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximate and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximate and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximate and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximately and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximately and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximately and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximately and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximately and the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, approximately and the death of th		1 Burial 2 Cremation 3 Removel from State 4 Donatton 5 Other (Specify)										e NY	
Immediate Cause (Final disease or condition resulting in death)   Due to (or as a consequence of):		16 Shea Place New Rochelle										e NY	10805
24a. Was an autopsy performed?  24b. Wara autopsy performed?  24b. Wara autopsy performed?  24b. Wara autopsy performed?  24c. Place of Death (Check only one)  25c. Was casa referred to medicel axaminer?  1	edical	frigf mutiated availt?	c									1 1 1 1 1 1 1	
24a. Was an autopsy performed?  24b. Wars an autopsy performed?  24c. Was an autopsy performed?  25c. Was casa referred to medical axaminer?  1		Part II. Other significant condition	a contributing to dea	th but not result	ing in the u	nderlying cau	se given i	n Part I.					
25. Was case referred to medicel axaminer?  1	pleted by									av:	ailable prior to mpletion of cause		
Content of Death   Content of	0							6. Place of	Death (	/		1/2	ăYas 2□ No
29a. Certifier (Check only one)  1 Certifying Physician: To tha best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	Hospital: 1   Inpatient   2   Reprodupationt   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other   4   Nu								rred	arra PE	
29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)		4 Homicide  determined  determined  determined  determined  building, etc. (Specify)  found in hotel room							Ba	25. Location (Street and Number of Rural Route Number, City or Town, State) 300 Light Street Baltimore, Maryland			
	edical	(Check only 27 Medicat Ex	aminer: On the bas	ils of examination		vestigation, in	my opini	on, death o		at tha time,	data and place	, and due to	the cause(s)
	2	O.C.M.E. November											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore, Maryland 21201  State 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture	/	David R	For b!	-	1		n St	reet,	Ba	ltimor	e, Mary	land	21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED item#4a&10e,(perMD/FD),11/09/00,SRR,TalbotCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth 740 **Physician** 00 Mary Gaines /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give streat and number) Examiner Battsneck Rd. Stevensville
If Under 24 Hrs. 8. Date of Queen Anne if Under 1 Year 8. Date of Birth (Month, Dey, Year) 9/16/29 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 215-16-2629 1 M 2 KF Yrs 529 71 Director Md. Usuei Residence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 R No Director Md. Queen Anne Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1712 Batteneck Rd. 21666 U.S. Funeral death Race - Americen Indian, Bieck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 M No Specify: Black Specify: à 3 ₩Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Maintaince Labor 10 other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill ment of Health end Mental Hant: If Item 27 is marked oth jury or other traumatic even Be Linwood White Florence Wright 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 1721 Battsneck Road Stevensville, Md21666 Louise Sewell 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 🗟 Cremation 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crem Salisbury, Md. 21. Signature of Funeral Sa 22. Name end Address of Facility Easton, Md. 21601 Dashiell Funeral Service 322 East Ave. 23a. Pert1. Enter the diseese, or complications that ceused shock, or heart failure. List only one cause on eech line ath. Do not enter the mode of dying, such as cerdiac or respiratory errest **Physician** /Medical Immediate Ceuse (Final Oweeks masses Luna diseese or condition resulting in death) Examiner Examiner robuble ung Cancel that the death certificate be executed physician and s the buriel-trans Sequentielly list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last to bacco abuser Division of Vital Records, P.O. Box 68760, Former Physician/Medical Due to (or es e consequence of) attending pl 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of cause of death? page 2 s has 1 ☐ Yes 2 ☐ No certificata or Attending Physician; funeral director, 25. Was cese referred to medicel exeminer? Be 26. Piece of Death (Check only one) Other: 4 ☐ Nursing Home 5 Hesidence 6 ☐ Other (Specify)
Injury et 28d. Bescribe how injury occurred 1□ Yes 20 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 1 Natural 2 Accident 5 Pending investigation after death. 1 Yes 2 No n 24 hours after dag ne Funeral Director pletaly filled in by th 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely I (Check only one) 29b. Signature and file of cert 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar 31. Date filed (Month, Day, (Year) NOV 0 9 2000

Daniel Jay

Konick M.D.

32. Registrar's Signeture

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

130 Love Point Rd., #107 Stevens. 1/k, M) 21666 B. Sparks

THE RESERVE AND ADDRESS OF THE PARTY OF THE the participance in the first or  Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Groshon Kathryn Louise **Physician** 10:40P NOV DO 09 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Healthcare Center Westminster Carroll County If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5, Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1□ M 25 F 220-16-0501 Director Mar. 6, 1923 Maryland Usual Rasidance of Decedant the Maryland 10a Stata 10h Count 10c. City, Town or Location 10d. fnsida City Limits pernit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified as 1 X Yas 2 No Director Maryland Carroll County Westminster 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 200 St. Luke's Circle 21158 United States Funeral 11. Marital Status 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 🕱 No If Yas, Giva Yaar or Datas: 1 □ Navar Marriad 2 □ Marriad Baltlmore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: Aq. Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) College (1-4or 5+) textile manufacture seamstress 10 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Harry William Dinterman Daisy K. Moser Lo 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Frances R. Francis / daughter 1468 Landis Circle Belair, Maryland 21015 20b. Placa of Disposition (Nama of camatary, crematory or other placa) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Nov 13 Keysville Union Cemetery Keymar, Maryland 2000 22. Nama and Addrass of Facility Skiles Funeral Home 21. Signatura of Funaral Sarvice Licanse M01072 136 East Baltimore Street Taneytown, MD 21787 lun un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata intarval Batween Onsat and Death **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in death) years Examiner Dua to (or as a consequence of) physician and s the burial-transit Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseasa or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t d be detech 1 ☐ Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of causa of daath? page 2 2 No 1 □ Yas 2 □ No certificete To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 ☐ Rasidanca 8 ☐ Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mennar of Death Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation Natural 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Street and Numbar or Rural Routa Number, City or Town, Steta) filled in by 4 Homicida Cartifying Phyalclan: To tha best of my knowledge, death occurred et tha time, dete end place, and due to the ceuse(s) end manner es steted.

Medical Examiner: On tha basis of axamination end/or invastigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and mannar steted. 29a. Cartifiar Medical 29b Signature and title of garaties 29c. Licansa number 29d. Date signed (Month, Day, Year)

104N Mary

State Registrar

30. Nema and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

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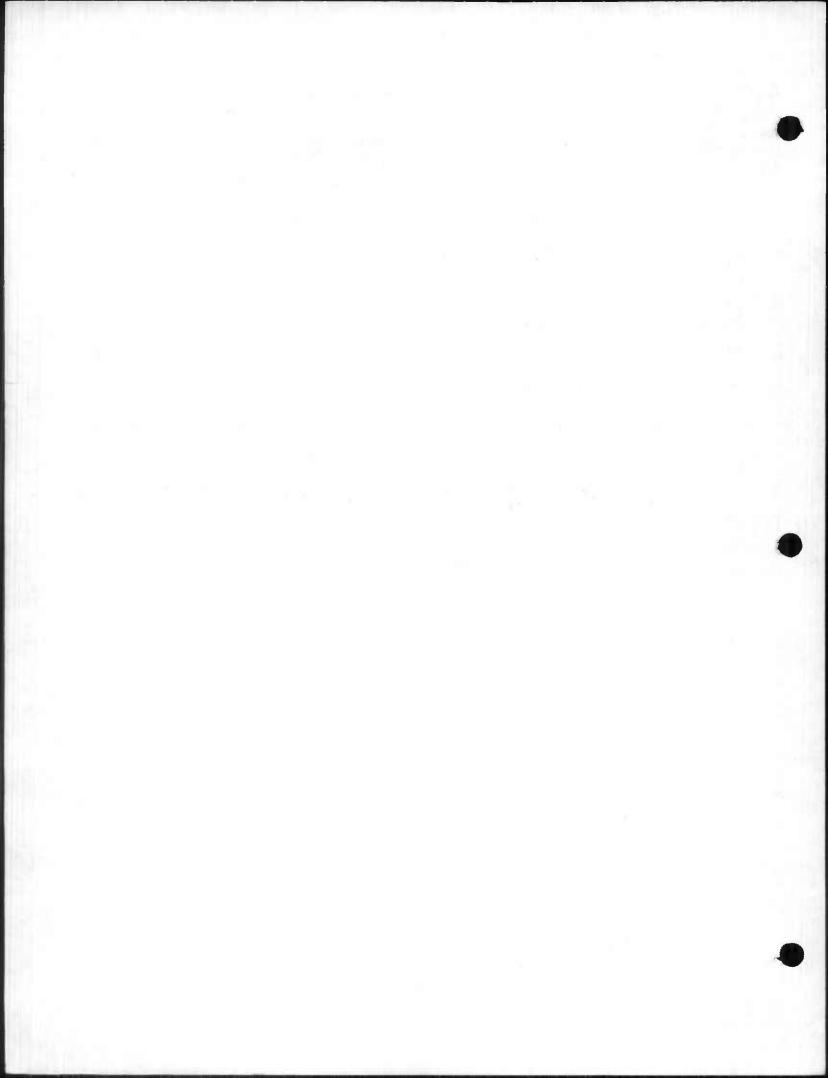
32. Registrar's Signature

Geneva

MARICOTE

31. Data filad (Month, Day, Yeer)

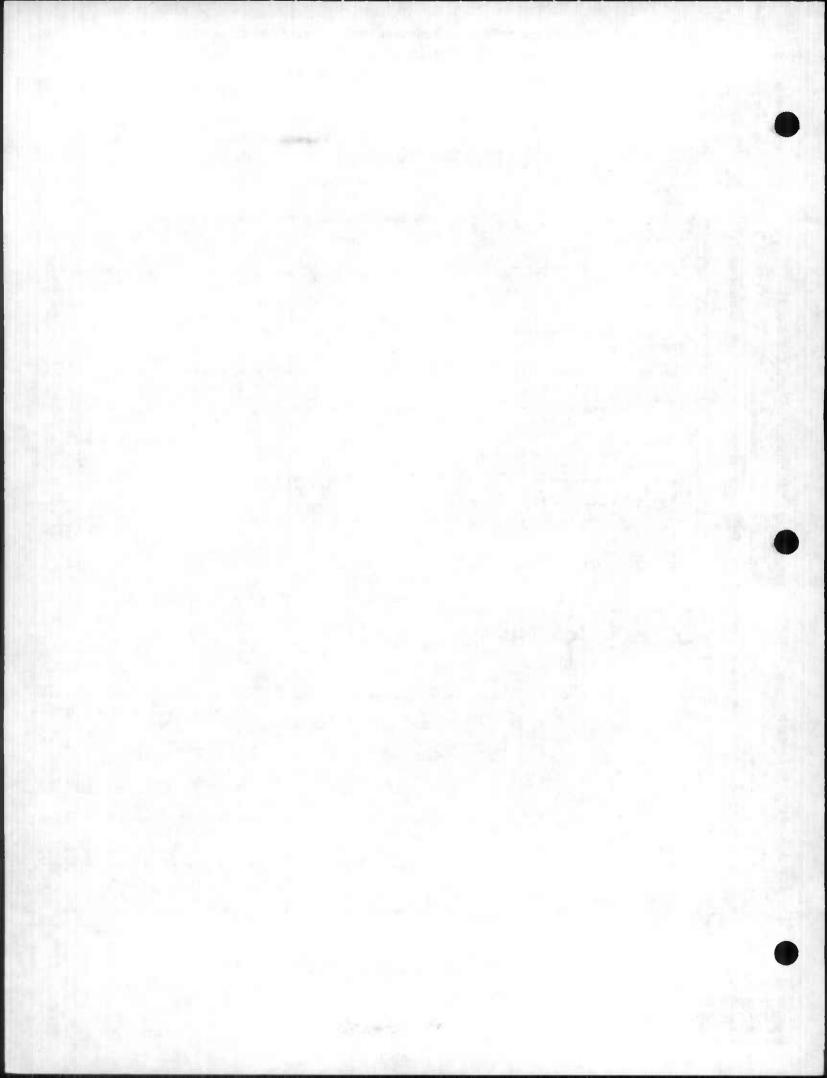
NOV 13



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37396

MILTON				Cer	tificate	of E	Death		F	Reg. No.		
B1 111	Month Day Year										3. Time of Death	
Physician /Medical	wavne				NOVEME	BER 03,	21:00 PM					
Examiner	Wayne J. Hamilton  4a Fecility Name (If not institution, give street and number)  6608 OLIVER STREET						City, Town		cation of Death	,	c. County of Deeth PRINCE GEORGES	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Undar 1	Yaar Days	If Under 24	4 Hrs.	8. Date of Birth (Month, De)	Year)	9. Birthp	lace (State or Foreign
Director	578-56-4951	1€M 2□ F	59	Yrs.	NOTITIES	Jays	lys Hours Min.		6/14/4			
2	Usual Residence of Deceda 10a. State 10b. C		10c City	, Town or Lo	cation						11	0d. Inside City Limits
or 28a-f sho be notified at							-	-Cap	itol He	Heights XXYes 2□No		
				10f. Zip Code 20743					10g. Citizen of What Country? U.S.A.			
after death or there 23 since matt	11. Maritel Status 1  Never Married 2  □	cedent Ever in U.S Forces? 2 2 No Give		. 13. Was Decedant of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, atc.)					Bleck, White, etc.			
and and a		1 ☐ Yes 2 ☐ No Specify:						Specify	y: B]	Lack		
ed within 72 hours at ygene. Net then 'natural', or it, the Medical Exam.	15. Dec (Specify only	15. Decedent's Education (Specify only highast grade completed)					tion u <i>ring most d</i>	ng	16b. Kind of Business/Industry			
the Ma	Elementary/Secondery (0	- 'ife. DO NOT use retired) Animal Caretaker						U.S. Government				
. 2522		liddle, Last)		AII.	Illiai C	- 1		's Neme	(First, Middle,	Maiden Sumen		ment
Abental H Abental H Head old Ilic ever	1 1 1 7	and the same of the same of							an Gord			
and h	19a. Informant's Name/Rel									or, City or Town,		Code)
and a	Eileen Davis	s/Sister					e.,Cap	pito	1 Hgts.		20743	
T to T	20e. Method of Disposition	ation 3 Removal from	04	lece of Dispo emetery, cren	sition (Neme netory or oth	of or place			Dete	20c. Location - City or Town, State		
timent taint dury	4 Donation 5 □Ott	15-8 Buriel 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify)						1/9/	00	Landover, Md.		
Separation of the separation o	21. Signeture of Funerel Se	ervice Licensee	> _	22	H.S.	Addres: Wasl	s of Facility hingto	on &	Sons C	Co., Inc.		
00240	23a. Pert1. Enter the diseas shock, or heert feilure	y W.	race		4925	Bur:	roughs	s Av	e., N.E.	, Wash.		20019 Approximata
death certificate be executed eatherding physician and of for use as the bunial-trensit is classificated.	Cause (Disease or injury that initiated events resulting in death) Last	b. ATTA	tus pr	r as a conseq	onnion juence of):	1250	uon	DI, SE	085,0	I'S DETE	55	
by the	Part II. Other significant co	enditions contributing to	death but not resu	ulting in the ur	nderlying ceu	se give	n in Part I.			obacco uss co Yes 2 No	ontributs to	the causs of death?
be de the back			24a. V							ere autopsy findings		
aw requir				P				erformed? a		aliable prior to mpletion of ceuse deeth?		
The lay							101	es 2 No	it	Yas 2□ No		
delan: The certificate rector, pag		edicel					26. Piace	of Death	(Check only o	ne)		
hysician his certif il directo	examiner?	Hospitat: 1 [	Inpatient 2	ER/Outpatien	t 3 DOA	Othe	er: 4 Nurs	sing Hor	ne 5 Rasio	danca 6 💆 Ott	ner (Specif	y) SCENE
		Pending 28a. Det	e of Injury onth, Day Year)	Injury Work?					ibe how injury occurred			
or Attending Physical or attending Physical or attentials in by the funeral diffication: To	2 Accident		10:50AM 10 Yes 2110				SUBJECT & SPIRATED OF FOOD					
tal or Attending P irs after death. Tal Director: After t led in by the funers Certification:	3 Suicida 6 C 4 Homicide	ne, farm, street, factory, office				11	281. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or within 24 hours after To the Funeral Dir completary filled in Medical Cert	29e. Certifier 1 Ce (Check only 2 Me	rtifying Physician: To the dical Examiner: On the and ma										
Within To the comp	29b. Signature and title of c			29c. License number				29d. Date signed (Month, Day, Year)				
(2)	30 Name and address of	ie Mecs	nell 1	OW.		OCM	E			NOVEMI	BER 0	4, 2000
(2)	30. Name and address of p	PA KOY	CEU			ree	t, Ba	ltin	ore, Ma	aryland	2120	1
State	31. Date filed (Month, Day,		Registrar's Signat	ture	,							
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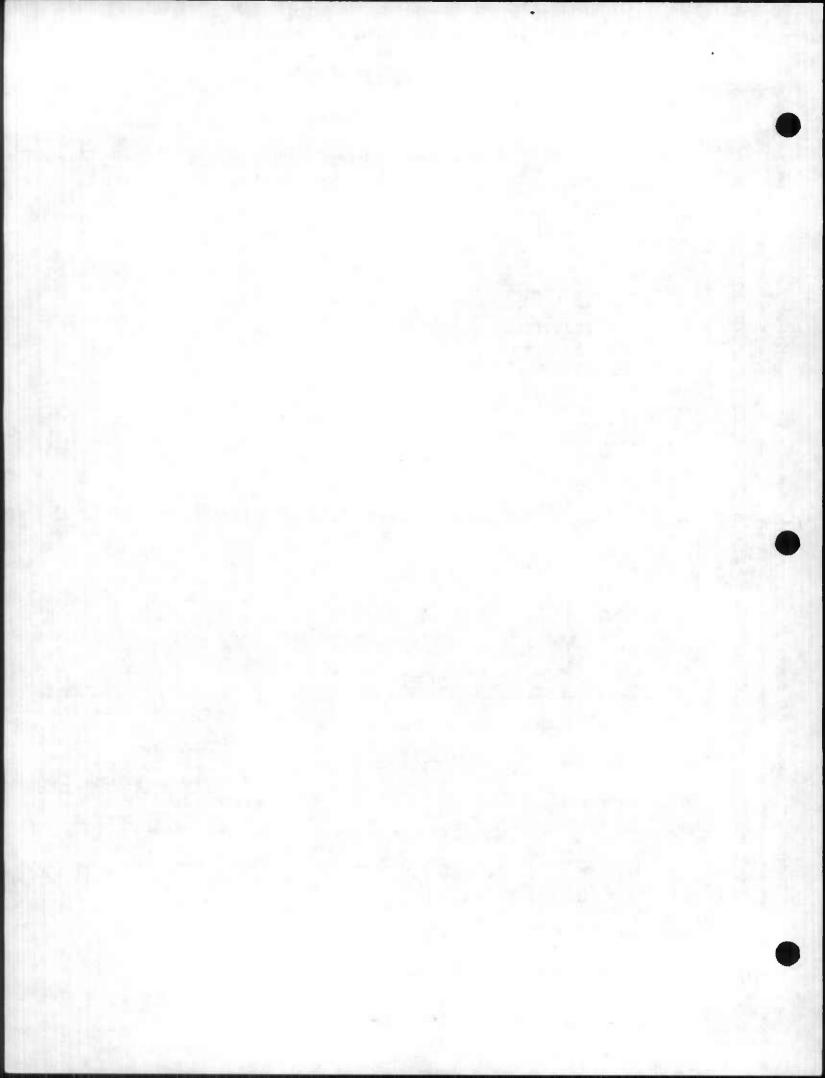
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Gary Blaine Herr, Jr. **Physician** NOVEMBER 05,2000 01:30 A.M. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, giva street end number) Examiner 9508 TEMPLE HILL ROAD CLINTON PRINCE GEORGE 's If Undar 1 Yaer | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthdey) **Funeral** Deys Hours 1 M 2□ F Yrs. **Director** December 8, 1978 Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince Georges Oxon Hill Maryland Yes 2 No Director 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 'natural', or items 23s or 7907 Indian Head Highway 20745 USA Funeral 12. Wes Dacedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Never Marriad 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes X No Specify: à 3 Widowed 4 Divorced Yaar or Detas: Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Housekeeper Industry 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be tilt.
Cepartment of Health and Mertal Hy important: if them 27 is merited oth any liquiry or other traumetic event 900s. Lori Jean Stanley Gary Blaine Herr, Sr. 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Jean Herr /Mother 7907 Indian Head Highway Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 🖾 Buriel 2 □ Cremetion 3 □ Removel from Stete Resurrection Cemetery 11/9/2000 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Road Oxon Hill, MD 20745 Enter the disasse, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory k, or heart feilure. List only one cause in each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es consequence of): Examiner The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest attending physician and for use as the burial-tran Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown λq 24b. Were eutopsy findings availeble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 1 PYes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE Hospitel: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 27. Menner of Deeth To 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Medical Certification: 28b. Time of or Attanding 5 Pending Investigation 1 Netural injury :19A notor vehicle collision 1 Yes 2 No death. 2 Accident after death Diractor: 11-5-00 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 9508 Temple Hills 1 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by Temple Hills Rd 4 Homicide Street within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier pietely and manner steted. 29d. Data signed (Month, Day, Year) 29b. Signeture end title of certifiar 29c. License number O.C.M.E. NOVEMBER 05,2000 but ? 30. Nama and address of person who completed ceuse of deeth (Item 23a) (Type, Print) ennis 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year)
NOV 0 7 2000 32. Registrer's Signeture State

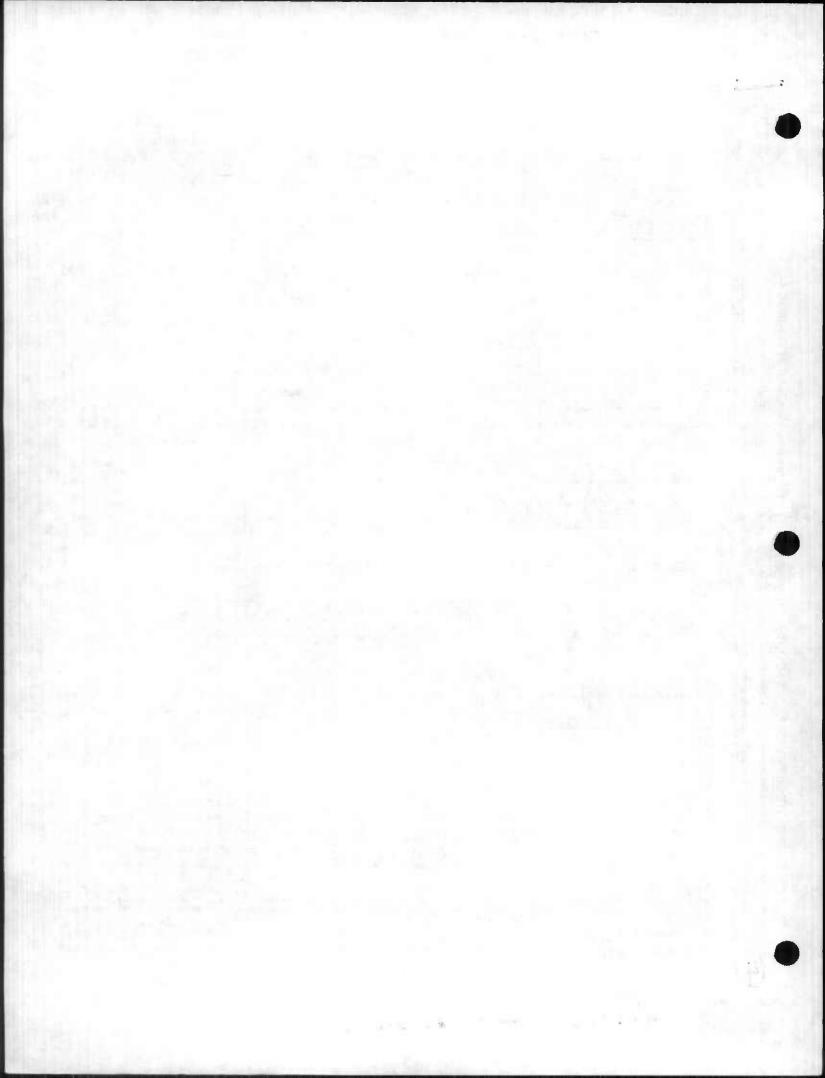
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Registrar



State of Maryland / Department of Health and Mental Hygiene 00 37398

Amend# 8	B.Per Fam.PGC 11-8	-2000 cr	Certifi	cate of	Death		Reg. No.		01030
	1. Decedent's Nama (First, Middla, La	st)				2. Data of De Month	ath Day	Year	3. Time of Death
Physician /Medical	Jamarr Keon	Hiers				NOVEMB	ER 03.	2000	15:45 PM
Examiner	4a Facility Name (If not institution, give	re street and number)				r Location of Deat	4c. County	of Death	
	PRINCE GEORGES			Under 1 Year	Cheves				ORGES
uneral rector	5. Social Security Number 6. S 219–96–2025			onths Deys			y, Year)	9. Birthp Cour Mary	place (State or Foreign ntry) Land
Š u	10a. State 10b. County	100	c. City, Town or Location	n	110			1	IOd. Inside City Limits
ner must be notified at uneral Director	Maryland Prince G	eorge's	Capitol He	eights					1 No Yes 2 No
al Direc	10e. Street and Number 1901 Brooks Drive	#103		of. Zip Code 20743			10g. Citizen of V	What Cour	
uner.	11. Maritai Status	12. Was Decedent Evar Armed Forcas?	in U,S. 13. Was	Decedent of	Hispanic Origin? (	(Specify Yas or No arto Rican, etc.)	- 14. Rac	e - Americ	can Indian,
by F	Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Yaar or Datas:		Yes 2 No		into rican, etc.,	Specify	Blad	
ated oted	15. Decedent's E (Specify only highest gro		16a. Decedent'	s Usual Occu	pation during most of w	orkina	16b. Kind of Bu	usiness/In-	dustry
Completed	Elementary/Secondery (0-12)	College (1-4or 5+)			during most of w				
	10th		Labo	rer	1 44 44 4 4 4	- 15 · 14:4-4		ivat	e
e e	17. Father's Nama (First, Middla, Last					ame (First, Middle	, Maioen Suman	(H)	
2	James Harr					te Hiers	- 04 -	Cu t C	Codel
	innette Hiers /Mo					Ru <i>ral Route Numb</i> 3 Capito:			
	20a. Method of Disposition		Ob. Place of Disposition		1100	Date	20c. Location -		
	f Burial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from State	cemetery, cremato Harmony Mer	ry or other pla		11/11/00		-	
8	21. Signature of Femeral Service Lice	nager	22. Na	me and Addr	ess of Facility	ral Home			
8	14.18	Jan 1.				d, Lando	war Mar	err 1 om	4 20705
	23a. Parvi. Enter the disease, or com shock, or heart failure. List only	plications that caused the						yran	Approximate Interval Between
ner	Immediate Cause (Final disease or condition resulting in death)	a. Head	to (or as a consequen		urie	2		1	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as a consequent	ce of):				1	
Medical Examir	that initiated events resulting in death) Last	Due	to (or as a consequent	e of):				8	
Physician/N	Part II. Other significant conditions of		t societion in the under	hing sausa s	ives in Bod I	22b Did	tohecco use co	ntribute t	o the cause of death?
should be detached for use leted by Physician/N	Partitional agricultural conditions	Onthibuting to death but no	resulting in the under	ying cause g	TOTAL TOTAL		Yes ABINO		bably 4 Unknown
v Q							an autopsy prmed?	av	fere autopsy findings vallable prior to ompletion of cause death?
TO.						13	¥es 2□No	O	Myes 2□ No
Completely filled in by the funeral director, page  Medical Certification: To Be Com	25. Was case referred to medicat examiner?				26. Place of D	eath (Check only	one)		
To	1 Dives 2 No	Hospitel: 1 ☐ Inpatient	2 ER/Outpatient 3	DOA O	ther: 4 Nursing	Home 5 ☐ Resi	dence 6 Oth	er (Speci	fy)
OD:	27. Menner of Deeth  1 Natural 5 Pending	28a. Dete of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. Inju			how injury occur		
satio	2 Accident investigation	11-3-00	@ 1500p		Yes 2 No		hicle Co		
Certification:	3 Suicide 6 Could not b 4 Homicide determined		At home, term, street, pecify)	factory, office		Sity or To	Street and Number, Stete) Pr	202	al Route Number,
edical		niner: On the best of my niner: On the basis of exa and manner stated.				ce, and due to the	ceuse(s) end ma	anner as s	stated.
2	29b. Signature and title of certifiar		- E E E E	29c. Lican	ise number		29d. Date signe	d (Month,	Day, Year)
)		- J Chi		oc	ME		NOVEMBE	ER 04	, 2000
		nteva	111 Pe	nn Str	eet, Bal	timore,	Maryland	1 212	201
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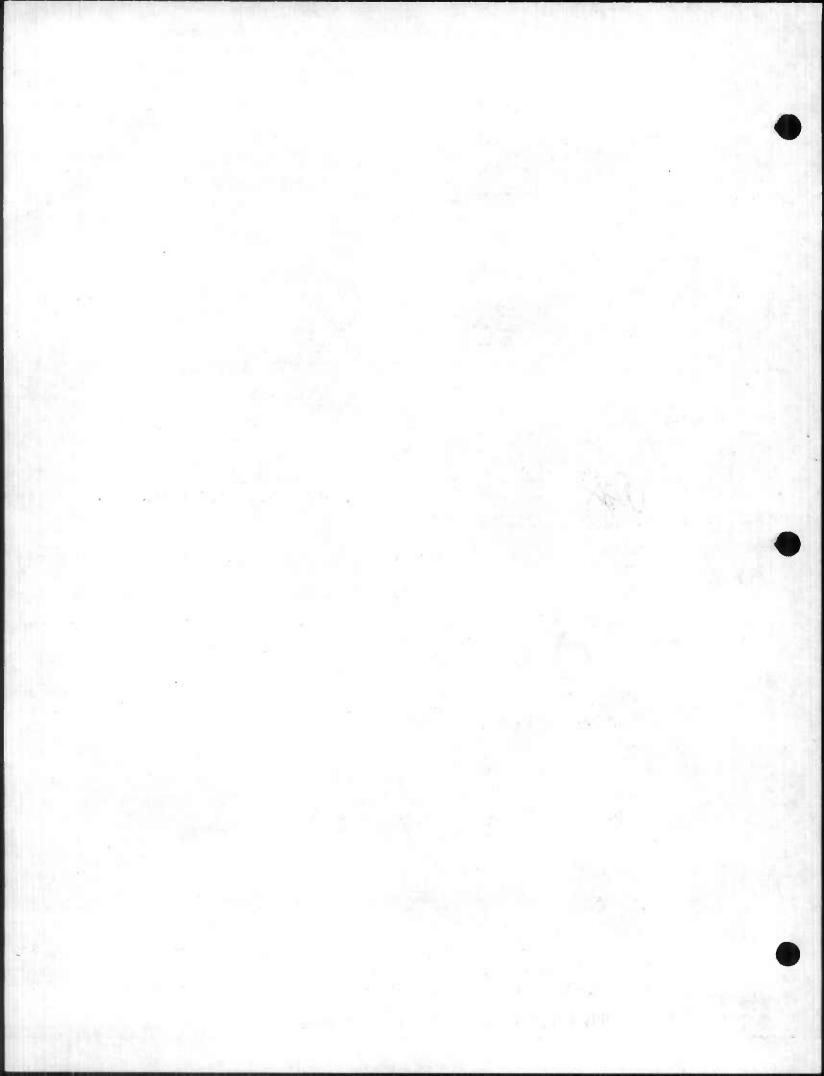
State of Maryland / Department of Health and Mental Hygiene

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					Cei	rtificate	e of	Death			Reg. No.		
Physicial		eme (First, Midd		MARY HA	NSON					2. Date of De Month Nevern	Dey	Year 2006	3. Time of Death
/Medica Examine	4e Facility Nam		on, give street end no					4b. City, To		ocation of Deet		y of Death	
Funeral Director	5. Societ Securit 218-40	-0930	6. Sex 1□ M 2□ F	7. Aga (In yrs. las 82	Yrs.	if Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De 8 / 5 / 1	oth 9y, Year) 918	Cour	olace (Stete or Foreign ntry) VA.
the Maryland 28a-f show notified at	Usuel Residence 10a. Stete MD •	10b. Count	ROLL	10c. City,	Town or LO							1	10d. inside City Limits 1 ☐ Yes ♣C★No
n with the Ma 23e or 28e-f s at be notified	10e. Street end	Number BLOOM	RD.			10f. Zip	Code 0 4 8	3			10g. Citizan of USA.	What Cour	ntry?
-0036 Thours after des furel*, or fems all Examiner m	3 ☑ Widowe	erried 2 Me	rried Armed F	2 No		Wes Deced f Yes, spec 1 Yes 2				ecify Yes or No Rican, etc.)		ce - Americ eck, White,	atc.
21215-0 d within 72 ho plents. or than "natur the Medical			nt's Education est grade completed College		(Give	dent's Usua kind of wor DO NOT us HO	k done e retire	during mos	t of work	16b. Kind of Business/Industry HOME MAKING			
Daniel de	17. Father's Ner			entrout						a (First, Middla HOFF	n, Maiden Suma MAN	me)	
more, Mary Pages 1 and 2 shou ent of Health and M not: If them 27 is man ry or other traumat	JAMES Armentrout EFFIE  19e. Informent's Neme/Relationship (Type, Print)  19b. Mailing Address (Street end Number or KATHY KNICELY - DAUGHTER 538 WILLOW AVE.,  20a. Method of Disposition  1  Burial 2 Cramation 3 Removal from State 4 Donetion 5 Other (Specify)  EVERGREEN MEM.GARDENS										STER,	MD .	21157 own, Stete
Baltim Permit. Pr Department Important any Injury odds.	4 Donetic			EVER	22	. Neme en	d Addre	ess of Fecili	v FL	ETCHER	FUNEF	RAL H	
Conflicate be executed with the property of th	Cause (Diseese that initiated ever resulting in deal	ition  conditions, commediate nderlying nots	b	Due to (or e  CARD)  Due to (or e  SEPS)  Due to (or e	09E	W/C juence of):	5	hoc	K	AILUK	E.		15 day 4 day
P.O. Both nat the death deteched for the attendance deteched for the attendance deteched for the deteched fo	Part II. Other sig	~ .	ions contributing to a					ven in Pert	I.		tobacco use c	ontribute to	o the cause of death?
cords, requires should be										24a. Was	s an autopsy ormed?	60	/ara autopsy findings /eileble prior to ompletion of cause death?
- F 40 (	25. Was case re	eferred to medic							e of Deel	1 Check only	Yas 2X No	11	☐ Yes 2 No
Jing Phys	1   Yes 2   No							idence 6 Do		(y)			
DIVISION To the Hospital or Attance within 24 hours after dealt To the Funeral Director: completely filled in by the	3 Suicide 4 Homicid	de detan	mined 288. Plec buik	e of Injury - At hom ting, etc. (Specify)						City or To	own, Stete)		el Route Number,
To the Hospital within 24 hours To the Funeral completely filled	29a. Cartifiar (Check only one) 29b. Signeture	2 Medica		a best of my knowle basis of examinetion nner steted.	edga, daat n and/or in	vestigation,	in my o	ma, data ar opinion, dec se number	nd place, eth occur	and dua to the red at the time	cause(s) end n , data and place 29d. Dete sign	, and dua t	to the cause(s)
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	Dhuaiais	_	1. Decedent's Name (First, Midd	le, Last)	Tex III		190				2. Date of Deal Month	_	Year	3. Tima of Death
	Physicia /Medic	_	Leona Mari	Le Hudg	ins						Novembe	er 6, 2	000	12:24AM
	Examin	_	4a Facility Name (If not institutio					4			ocation of Death	4c. County		
			Carroll Cour				lf Under	1 Vans	West				arrol	
	Funeral Director		5. Social Security Number 215-07-1721 Usual Residence of Decedent	6. Sex 1 □ M 21公 F	7. Age (In y	rs. last birthday, 86 Yrs.	Months		Hours	Min.	6. Dete of Birth (Month, Day Aug. 22	, 1914	9. Birtho	elece (Stete or Foreign aryland
	Maryland a-f ahow	tor	10a. State 10b. County	arroll	10c.	City, Town or L	ocation	New	Wind	sor			1	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
	th with the 23a or 28	al Dire	10e. Street and Number 2509 Marston	Rd. Sout	h		10f. Zip		21776		1	0g. Citizen of V		ntry?
020	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or flerna 23a or 28a-f show ent, the Medical Externed must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☑ Widowed 4 ☐ Divorced	ried 1 Yes	2 🖾 No Sive	1 U,S. 13.	Wes Deced If Yes, spec	cify Cuba	ispanic Ori an, Mexicar Specify:	n, Puerto	pecify Yes or No- Rican, etc.)		k, While,	an Indien, etc. nite
21215-0020	within 72 ho lene. than "naturi	Be Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	T	(1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us homer	rk done se retired	during mos d)	at of worl	king	16b. Kind of Business/Indus		
Maryland ?	Duid be filed Mental Hygi arked other atic event, t	To Be C	17. Father's Neme (First, Middle, Alexander Wit						18. Mothe		e (First, Middle, I Julia Hr		10)	
ary	2 should and Mer e marke eumatic		19a. Informant's Name/Relations	ship (Type, Print)		19b. Meil	ing Address	(Street	and Numb	er or Ru	ral Route Number	r, City or Town,	State, Zip	Code)
	t and 2 Health a em 27 le other tree		Virginia Dykes	/ daughte					Rd. S	.,	New W			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylen Department of Heelih and Mental Hyglone. Important: if item 27 le marked other than "natural", or itema 23e or 28a-f ahow with highly or other treumatic event, the Medical Examiner must be notified at pace.  To Be Completed by Funeral Director		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removel from		b. Place of Disp cemetery, cre	osition (Ner emetory or o	ne of other plea	ce)		Date	20c. Location -	City or To	own, State
E			4 Donation 5 Other (5	Specify)	H	loly Rec						Baltimo		MD
Ba	Departiment Important International Internat		21. Signature of Funeral Service	W.Xa	Der	/ 2	310 C	d Addre	ss of Facili	^{ty} Har	tzler Fu New Wind	neral H sor, MI	Home 217	76
	Physician	23a. Part1. Enter the disease, or complications that based the deeth. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.									or respiratory arr	est,	1	Approximete Interval Between Onset end Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. Pn	eum	onia						2		Days
		- e				o (or es e conse								
	on insit	듣		b. 694	-	ntesti			MON	Mag	e		1	
oʻ.	cete be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury		Due to	o (or as a conse	quence ot):							
8760,	ysicia e bur	Cai	that initiated events	C	Due to	o (or as a conse	quence of):							
9		Med	resulting in death) Last	d										
Вох	etten etten I for u	Physician/Me	Date Out to the control of		4 4 5 4 3		Sala es				Ook Dida	******	-1-1-1-1-1	o the cause of death?
0	the d	hys	Part II. Other significant conditi			resutting in the	unaeriying d	ause giv	en in Part	1.				bably 4 Unknow
S, D	thet be deti	by P	Houte Non	awaye	MI							20110	00.10	
Records	been should	Completed	Atrial fib	willati	vn						24a. Wes a perfor	an autopsy med?	ev cc	ere autopsy findings eliable prior to empletion of cause death?
	The le	E									1 🗆 Y	es 200 No	11	□Yes 2□ No
Vita	ilan: artifica ctor.	Be	25. Wes case referred to medice axaminer?	-					26. Plac	e of Dea	th (Check only or	ne)		
	Physician: this certific ral director,	2	1 Yes 2 No			2 ☐ ER/Outpatie			4UN	ursing H	ome 5 Resid			fy)
Division of	Attending P or death.  ector: After the by the funeral	cation:									28d. Describe h			
DIVI	To the Hospital or Attending Physician: The lever within 24 hours after deeth.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Ple	ding, etc. (Sp.						City or Tow	n, State)		el Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical		ng Physician: To the Examiner: On the end ma										
	To t	29b. Signeture end title of certifier 29c. License number							29d. Date signed (Month, Dey, Year)			Dey, Year)		
			177519	ul /	M		0	000	5192	4	N	ovemb	e- 06	00000

State Registrar

DHMH 16 Rev 6/95

Herbert P. Henderson Jr. MD 295 stoner Aug Suite 307, West minster MD, 21157

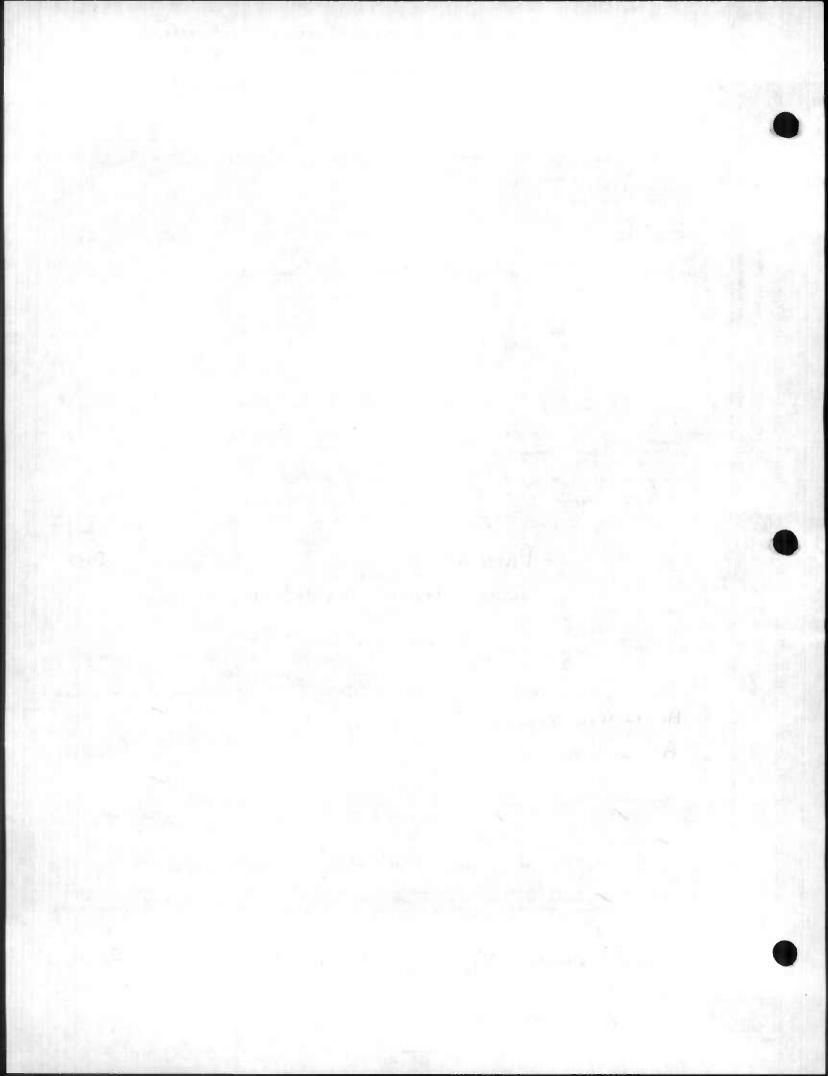
31. Date filed (Month, Dey, Year) | 32. Registrar's Signature

parks

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

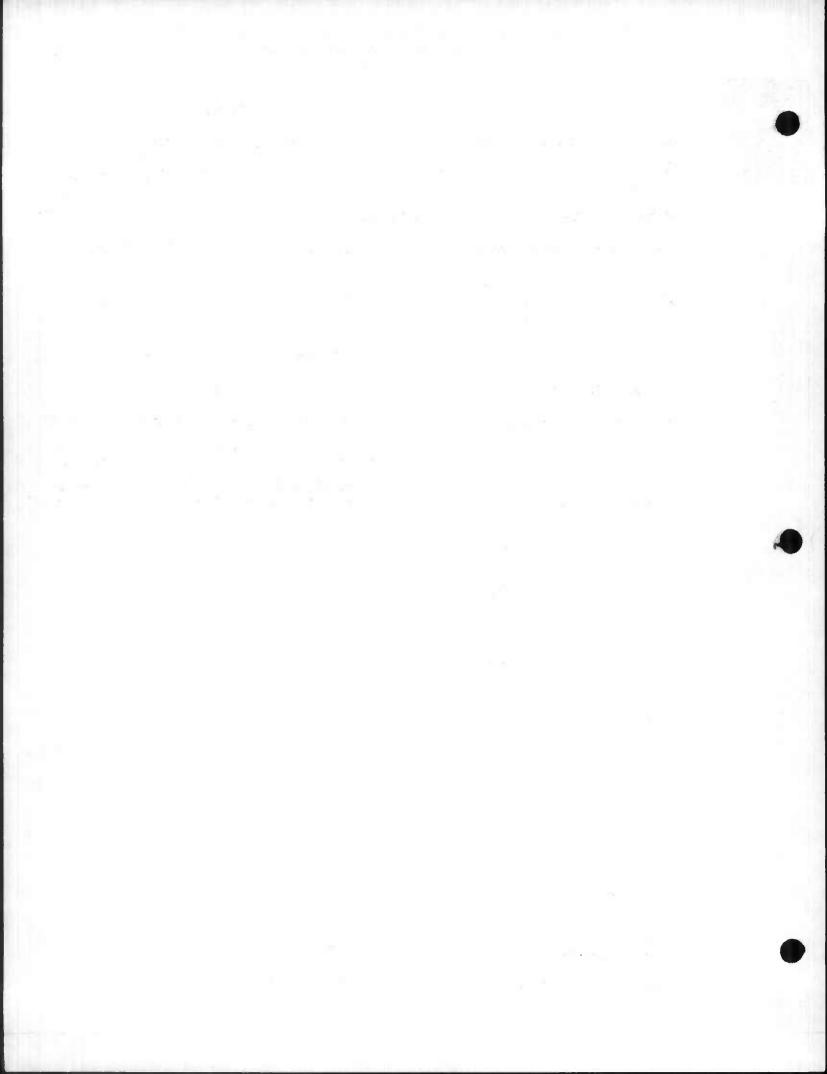
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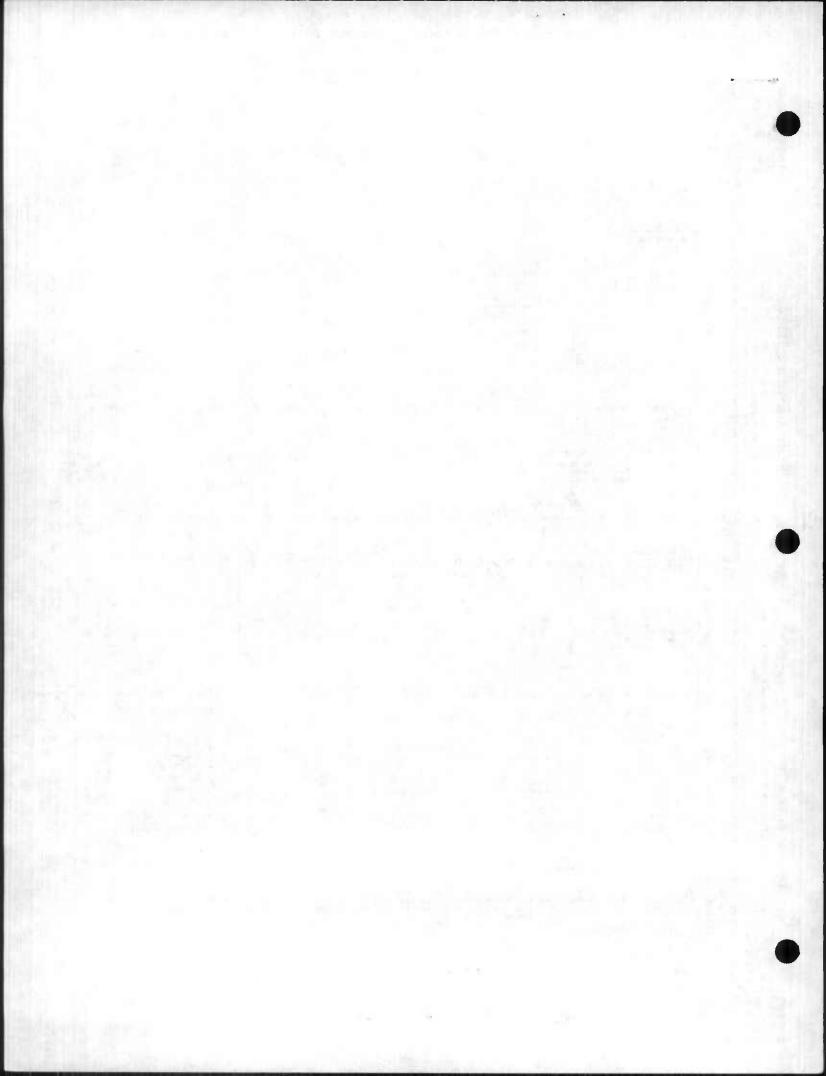
State of Maryland / Department of Health and Mental Hygiene 3740

					Certif	ficate of	Death		Reg. No.			
Dhusia		1. Decedent's Neme (First, Middle, La	est)		, 1	4.5		2. Date of De Month		Year 3.	Time of Deeth	
Physici /Media	cai	Carolyn R. Has				1	4b. City, Town, or	Novemb	er 17,	2000 1	1:00 ar	
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Funerai Director		5. Sociel Security Number 6. 5		(In yrs. last		Under 1 Yea lonths Deys	r If Under 24 Hrs	8. Date of Bird (Month, De		9. Birthpiece Country)	(State or Foreig	
,		Usuei Residence of Decedent		10.00.7		9		roday z	19 1061			
show	2	10a. Stete 10b. County  Maryland Howard			own or Locati						nside City Limit	
289-	Director	10e. Street end Number		EII.		10f. Zip Code			10g. Citizen of V		165 201	
23a or		4401 Cross Cou				210	042		United	States		
ral', or items 23a or 28a-f show Examiner must be notified at	by Funeral	11. Marital Stetus  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent II Armed Forces? 1  Yes 2 N If Yes, Give Yeer or Dates:			Decedent of es, specify Cu	Hispenic Origin? (S ben, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify	idlen,		
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- 20	Idm	Elementary/Secondery (0-12)	Coilege (1-4or 5	+)								
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th end Menta 7 Is marked traumatic ex	To	William Reynek  19e. Informent's Neme/Reletionship (			Oh Mailing A	ddrose /Stro	Anna Anna	Zimmermann  Rural Route Number, City or Town, State, Zip Code)				
27 Is r trau		Karen Busso / da					Country D		-		21042	
E E		20e. Method of Disposition	iug::cor	20b. Piece	e of Disposition		-	Data	20c. Location -			
0 ± 5		1 ☐ Burial 2 🛣 Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif					ece)	Nov. 20 2000	Catone	willo	MD	
Depertment Important: It any injury of odce.		21. Signeture of Funeral Service Licer	**	Met	ro Crer	ame and Addi	ress of Fecility			ville,		
Impo any ir		<b>▶</b> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			Har	ry H.	Witzke's					
ysician		23a. Pert1. Enter the disease, or com shock, or heert feilure. List only		the death. I	Oo not enter the	ne mode of dy	COLUMBLA ring, such es cerdia	P1Ke E1	Licott C	City, MD. 2104 Approximate Intervel Between Onset and Death		
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ettendi for use	Physician/I		d. 1711.00	<i>-</i>						1	9	
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(3 -	Be	25. Wes case referred to medical exeminer?	I I in - I					eth (Check only o	ne)			
ertific ector,		1 ☐ Yes 2 ☐ No	Hospital:		/Outpetient	3LI DOA		dome 5 Aesid				
nis certific I director,	T _o			y 28	b. Time of	28c. inju	ury et	28d. Describe I	now injury occurr	ed		
nis certific I director,		27. Menner of Deeth  **Daturel 5   Pending Investigation		Year)	Injury		Yes 2 □ No					
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4 nours ener death. Funeral Director: After this certific tely filled in by the funeral director,	edical Certification:	27. Menner of Deeth    Description	28e. Plece of Injubuliding, etc.  ysician: To the best of Injubulicians of the basis of Injubulicians of the Injubulicians of In	ry - At home . (Specify) f my knowled exemination	, ferm, street,	M 1[ fectory, office curred et the tigation, in my 29c. Licer	Yes 2 No	City or Too	vn, Stete) ceuse(s) and me date end piace, o	nner as steted and due to the	cause(s)	
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State of Maryland / Department of Health and Mental Hygiene 00 37402

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		1. Decedent's Name (First, Middle, Last)										2. Date of Month		y Yea		3. Tima of Dea
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/Medical Examiner	4 4 4	Facility Nama (i	If not institutio				OCITICALI	3	- 1	4b. City, To	wn, or Lo	ocation of De		County of De		
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uneral					M 2 F	59	yrs. last birting	Months		Hours	Min.	8. Data of (Month, 11/19	Day, Year)	N	Country	ork, N.Y
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r Nema 23a Miner must Funeral	11.	Marital Status		13	2. Was De	cedant Evar	in U,S. 1	3. Was Dec	edant of H	lispanic Ori	gin? (Sp	ecify Yes or Rican, atc.)	es or No- 14. Race - Americ			
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Da Da	-		15. Deceder				16a De	cedent's Us	ual Occur	ation			16b Ki	ind of Busines	es/Indus	etry
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aumetic To	t9a	. Informant's No	eme/Reletions	ship (Typ	e, Print)		19b. Ma	ailing Addra	ss (Street	and Numb	er or Run	al Routa Nur	nber, City o	or Town, State	e, Zip C	ode)
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- 12	204	1 Burial 2		3 □Ra	movat fron	Stata	cematary, c	ram atory or	othar plac		1					
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eny injury o	21.	4 Donation 5 Other (Specify)  Metropolitan Crematory 11/06/2000 Alexand:  22 Nama and Address of Facility Funeral Home  George P. Kalas Funeral Home														
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**JOHN** 

JONES

#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician
/Medical
Examiner.

JOHN MICHAEL JONES 4a Fecility Neme (If not institution, give street end number)

2. Dete of Death NOVEMBER 10,2000 3. Tima of Death 6:05P.M.

**Funeral** 

5. Sociel Security Number 006-62-0576

EASTON MEMORIAL HOSPITAL

EASTON 7. Age (In yrs. last birthdey) Hours

4b. City, Town, or Location of Deeth

4c. County of Deeth

TALBOT

the Maryland

should be filed within 72 hours after death

Maryland 21215-0020

Baltlmore,

Usuel Residence of Decedent 10a. Stete 10b. County

1. Decedent's Name (First, Middle, Last)

1 M 2 F

Months Deys Yrs.

8. Date of Birth (Month, Day, Year) June 7,1969 Maryland

Birthplece (State or Foreign Country)

10d. Inside City Limits

Director

28a-f show

8

234

Neme

6

"natural"

Hygiene.

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Mem 27

other

ŏ permit. Pege Department ( Important: If any Injury or poce.

Peges 1 and 2 s ment of Health an

other

the Medical Examiner must be notified at

Funeral Director

þ

Completed

MD Caroline 10e. Street and Number

10f. Zip Code

Preston

1 ☐ Yes 2 XNo

22830 Hog Creek Road

21655

United States

10g. Citizen of What Country?

11 Maritel Stetus

1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:

 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☐XNo Specify:

14. Race - American Indien, Black, White, etc.

White Specify: 16b. Kind of Business/Industry

Cambridge, MD

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12)

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Body Repair

Auto Body Shop

17. Fether's Name (First, Middle, Last)

12

Jackson R. Jones 18. Mother's Name (First, Middle, Maiden Surneme) Carole Ann Carter

11/15

19e. Informant's Neme/Reletionship (Type, Print)

31

10c. City, Town or Location

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 22830 Hog Creek Rd., Preston, MD 21655

Shawn Fannon Jones/Spouse 20e. Method of Disposition

20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Cambridge Crematory Dete 20c. Location - City or Town, State

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Funeral Service Licensee n chail Estern 22. Name and Address of Fecility

Framptom-Hawkins-Eskow Funeral PO Box 43, Federalsburg, MD 21632 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth

**Physician** /Medical Examiner

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physician

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2

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funeral director.

vd ni belli filled in by

this

After

after deeth.

I Director: Aft
d in by the fur

To the Hospital of within 24 hours a To the Funeral D

The law requires that the death certificate be executed

or Attending Physician:

P.O. Box 68760

of Vital Records,

Division

Physician/Medical Examiner

Be Completed by

Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

Immediate Cause (Final disease or condition resulting in death)

Due to (or es e consequence of)

Due to (or as e consequence of)

Due to (or es e consequence of):

that initieted events resulting in death) Lest

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 □ Yes DONO 3 Probably 4 Unknown

24e. Wes en eutopsy performed?

24b. Were autopsy findings eveilable prior to completion of ceuse of deeth?

Yes 2 No Yes 2□ No

25. Wes case referred to medicel 1⊠ Yes 2□ No

27. Menner of Death

1 Naturel

Accident

3 ☐ Suicide

4 Homicide

5 Pending Investigation

6 Could not be determined

28e. Dete of Injury (Month, Day Year) 110/00 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Hospitel: 1 ☐ Inpatient 2 XER/Outpetient 3 ☐ DOA 28b. Time of 720

111 Penn Street, Baltimore, Maryland 21201

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d, Describe how injury occurred Wer in outo acide

28f. Location (Street end Number or Rurel Route Number, City or Town, Syste) AE. 331 1an

29a. Certifier Medical (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the dause(s) and menner as stated. Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signal

29c. License number O.C.M.E.

29d. Date signed (Month, Dey, Year) NOVEMBER 11,2000

and address of person who completed ceuse of death (Item 23a) (Type, Print)

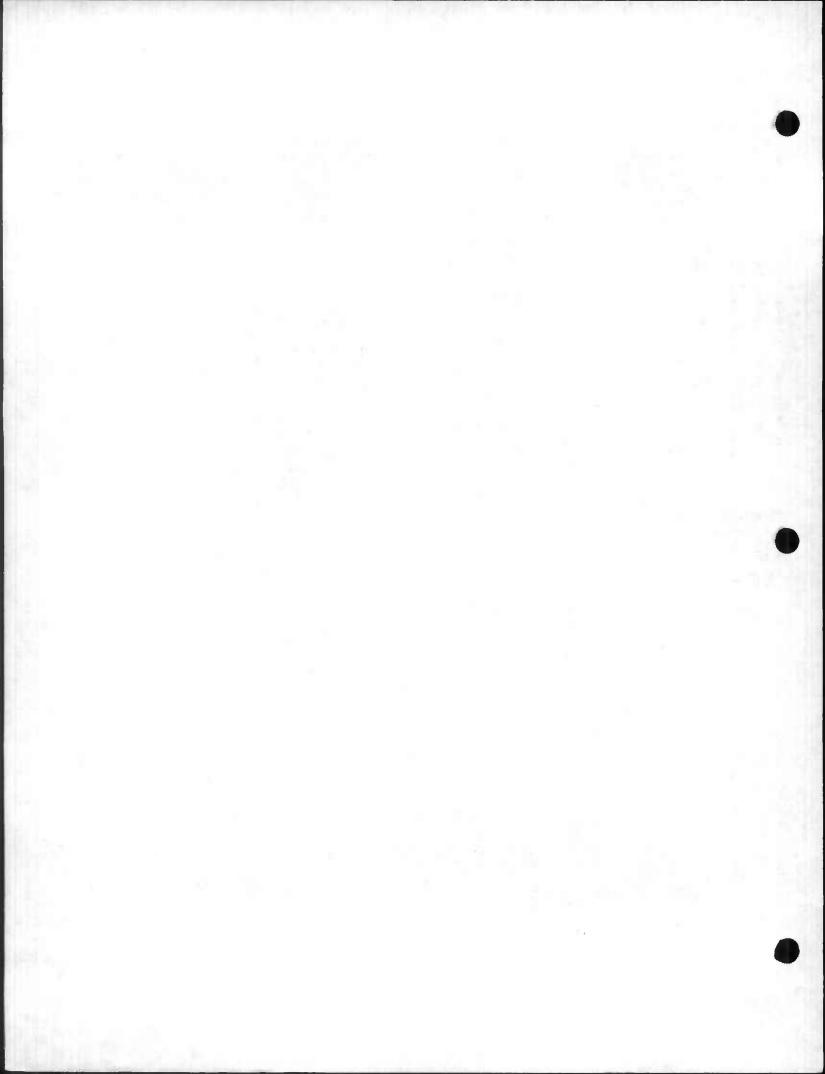
T. LARON ( 31. Dete filed (Month, Day, Year) NOV 1 4 2000

32/Registrer's Signeture

Registrar

State

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 40 P.M. Jackson, Sk Douglas Gaither Oct. 31 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 702 Righy
5. Social Security Number 9 Sex ambridge L If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dorchester If Under 1 Year Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Deys 120M 2□ F Yrs. 88 214-16-4526 Usual Residence of Decedent Director Maryland the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or itema 23a or 28a-f show Examiner nast be notified at 1 XYes 2 □ No Director MARY and Dorchester ambridge 10f. Zip Code 10g. Citizen of What Country? 702 11. Marifal Stafus Funeral Ave 21613 Kigby 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 "naturel", or 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorced Black Completed permit. Peges 1 and 2 should be filed within 72 hc Department of Health end Mental hygiene. Important: If item 27 le marked other than "natuneny injury or other traumatic event, the Mental and. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Farmer Farm 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be 10 Noah Jackson Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Pural Route Number, City or Town, Stete, Zip Code) 20b. Placa of Disposition Name of comercia, crematory or other place)

Date

20c. Location City or Town, State Shirley Jackson / daughter 20e. Method of Disposition
1 Disputal 2 Cremation 3 Removal from State Reids Grove Cemetary 11/6/2000 Keids Grove, md. 4 ☐ Donation 5 ☐ Other (Specify) or any ice Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical mo (espiratore Examiner Physician/Medical Examiner Metastatic CMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 0 3 Probably 4 Unknown coraestive (berdies Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? we Disorder 1 Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 446 Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation or Attending 1 Yes 2 N 24 hours after death.

Funerel Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) and manner stated. 29e. Certifier within 24 ho To the Functional (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2 211284 0, Qe 116100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**DHMH 16 Rsv 6/95** 

State

Registrar

31. Date filed (Month, Day, Year)

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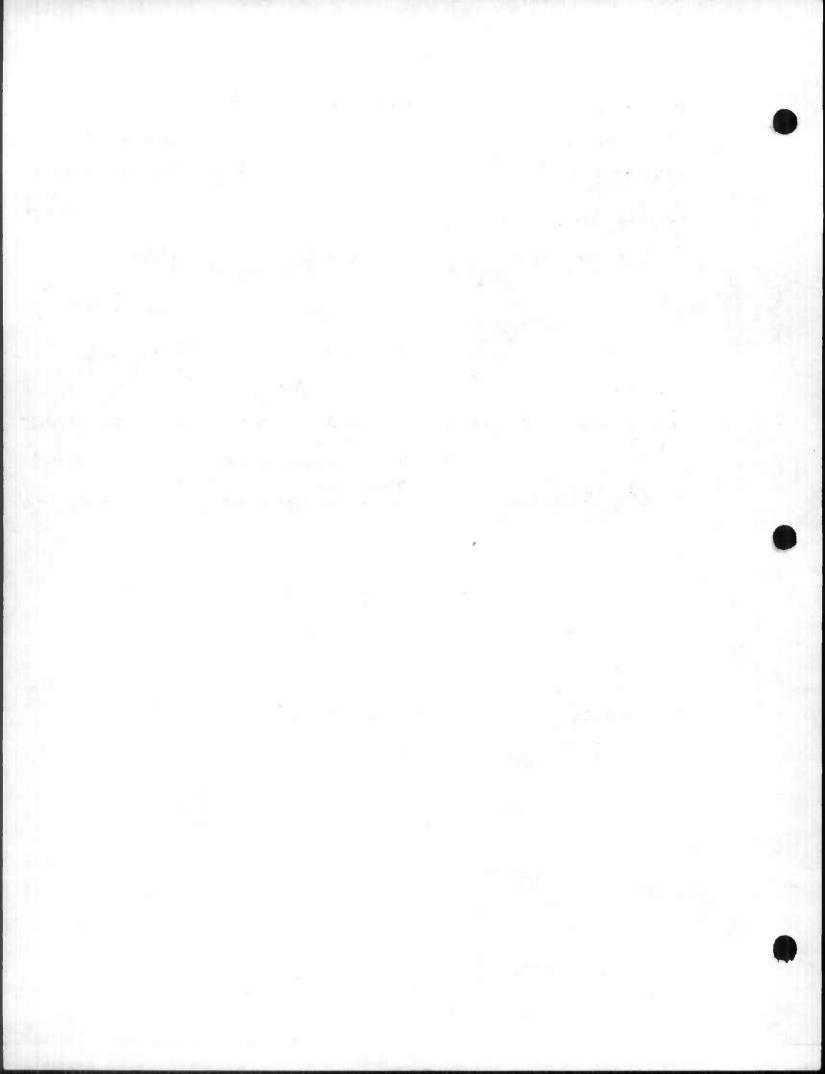
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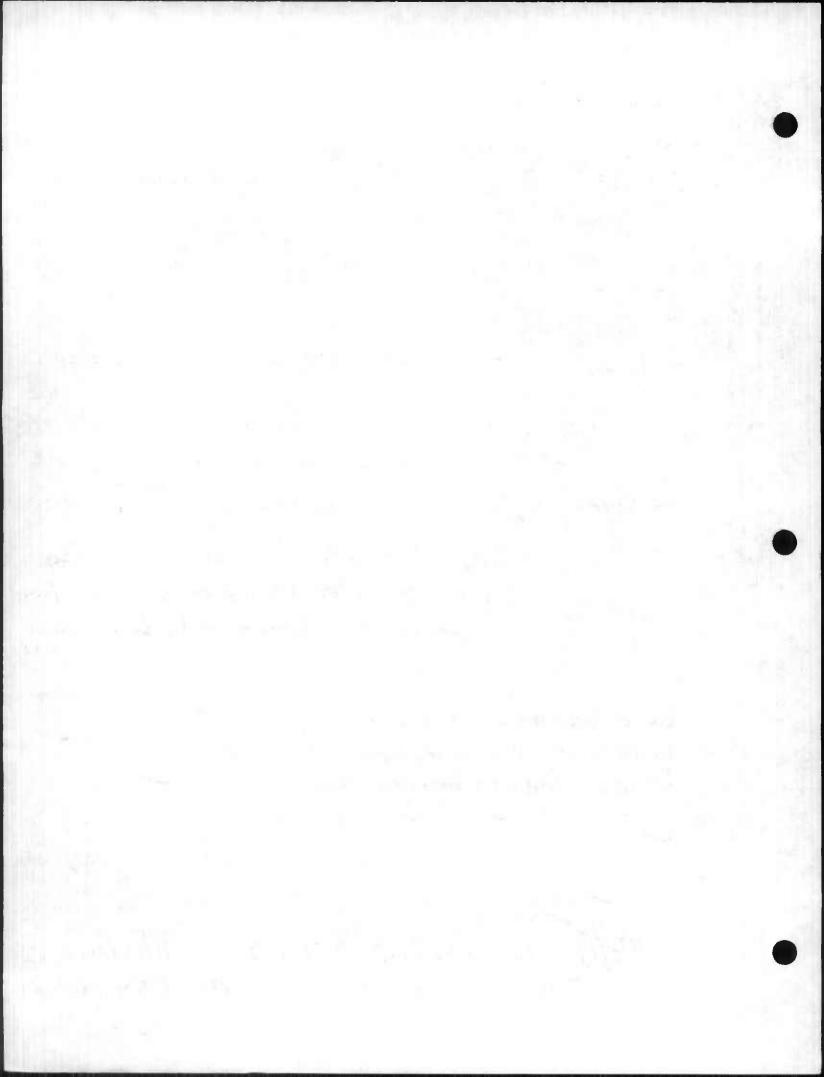
32. Regisfrar's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UU 37405

						Cei	tificate o	of Death	F	leg. No.				
Physicia /Modio		1. Decedent's Nen Laurer	me (First, Middle, Lance Lee		Sr.				2. Dete of Dea Month	Dey Year				
/Medic Examine		4e Facility Neme	(If not institution, gi	ve street end nu	m <i>ber)</i>			4b. City, Town,	or Location of Death	4c. County of De				
		Washir	ngton Cou	nty Hos	oital			Hagers	town	Washing	gton			
Funeral		5. Social Security		Sex	7. Age (In yrs.		If Under 1 Ye		Hrs. 8. Dete of Birth	Year) 9. B	irthplace (Stete or Foreign Country)			
Director		218-30-8	3/25	10 M 20 F	64	Yrs.				20, 1936	Maryland			
2 .		Usuel Residence	of Decedent 10b, County		10c Cit	y, Town or Lo	cation				10d. Inside City Limits			
sho sho	*	MD	Washing	ton		agerst					1 ☐ Yes 2 ☐ No			
28e-f	Director	10e. Street and Nu		<b>C</b> O11	110	4601300	7	4-		10a Citizan of Milat	Λ			
							10f. Zip Cod			10g. Citizen of Whet (	200mily?			
m 23	eral		shington		edent Ever in U	c 12 1	217		2 (Specify Ves or No.	U. S. A.	nerican Indien,			
2 0 0 0	by Funeral		rried 2∑ Married	Armed Fo	orces?		Yes, specify (		? (Specify Yes or No- uerto Ricen, etc.)	Specify: W	nite, etc.			
5-002 72 hours natural'.	ted	10	15. Decedent's E			16e. Deced	lent's Usuel Oc	cupation		16b. Kind of Busines	ss/Industry			
215 En . m . m	Completed	Elementary/Sec	conderv (0-12)	College (	1-4or 5+)	life.	DO NOT use re	one during most of tired)	working					
Man and and and and and and and and and a	Con	10			-	Trac	tor-tr	ailer Dr		Private Industry				
nd 2	Be (	17. Fether's Neme	(First, Middle, Las	1)				18. Mother's	Name (First, Middle,	Meiden Sumeme)				
hould be ad Mental marked o	2	Clarence	ce Norman	Karn				Saral	n Ellen Ro	her				
Aland Name			Neme/Reletionship								, Zip Code)			
n and			ve V. Kar	n / spou					Hagersto		1740			
Ores de la constante de la con		20e. Method of Dis	sposition Cremation 3 l	Removal from		Place of Dispo semetery, crer	sition (Neme onetory or other	f plece)	Dete	20c. Location - City of	or Town, Stete			
Page Manual Page M			5)□ Other (Spec			st Have	en Ceme	tery	11/15/00	Hagersto	own, MD			
Sall Sall Sall Sall Sall Sall Sall Sall		21. Signeture of F	usural Service Lice	msee 7		22	. Name end Ad	dress of Fecility	Rest Haven	Funeral (	Chanel			
n sersa		401	int C.	11/04			601 Pe		ia Ave. H					
		23e. Part 1. Enter	the disease, or core	nplications thet	aused the deet				diac or respiretory er		Approximate interval Between			
Physician						76	Onset and Deeth							
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Examiner		resulting in deeth)	)		Due to (d	or es e consec		ii	H					
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be ex ician buria		Sequentielly list of eny, leeding to it cause. Enter Und Ceuse (Disease of	derlying or Injury	C	Your	tmau	CE	u (Au	Cinana	Vi-len	- MANCH			
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attendi for use	by Physician/		91 11 11								1			
the de	ysi	Pert II. Other sign	ificant conditions	contributing to d	eath but not res	ulting in the u	nderlying ceuse	given in Pert I.			ite to the cause of death?			
that the ed by	P	Raci	T WYO	CANDU	n/V	FANC	TLONS	,	100	2 No 3	Probably 4 Unknown			
requires t	d b		/	. 0			,		24a. Wes	en eutopsy 24l	b. Were eutopsy findings available prior to			
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ne law requiring has been singe 2 should	Completed	T.		7	- /		-							
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Physician: this certific ral director,	Be	25. Wes cese refe examiner?		Hospitel:	/			Other	Deeth (Check only o					
hys bys	. To	1 ☐ Yes 2 €	No	164		28b. Time of		4 LI NUISI	ng Home 5 Resid	lence 6 Other (S) now injury occurred	pecify)			
oding 1 th. After funer	ion	1 GNaturel	5 Pending		ot Injury th, Dey Year)	Injury		Injury et Work? 1 ☐ Yes 2 ☐ No		low injury occurred				
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or A or A Direc	Certification:	4  Homicide	determine	200. PIECE	ot Injury - At hing, etc. (Specif	fy)	eet, rectory, on	ice	City or Tow		rigial riggie realibal,			
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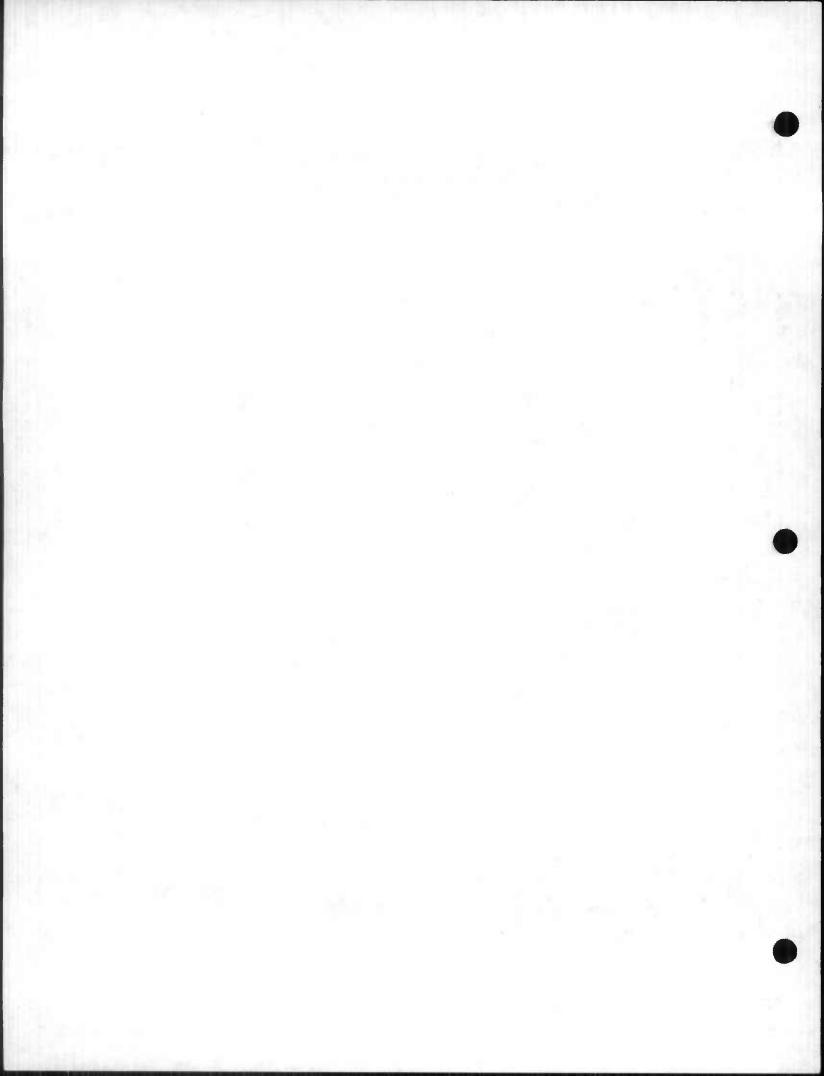
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	Physiciar		1. Decedent's Name (First, Middle  JASON L.	Last)	SER	00 11					2. Date of De Month	Dey	Year	3. Time of	
	/Medica	-	4a Facility Name (If not institution					4	b. City, To	wn, or Lo	NOVEIT Deat			2:20	Р.М.
	Examine	r	Motel 6, 1654			Room	351			odla		Balt			
-	Funeral		5. Social Security Number	6. Sex	7. Age (fn yrs	s. last birthday,	If Under 1		If Under	24 Hrs.				ce (Stete or	r Foreign
	Director		183-58-2485	1∭ M 2□	23	Yrs.	Months	Deys	Hours	Min.	8. Date of Bi (Month, Da Oct 18	1977	Waynes	boro, I	PA
	g ,	-	Usual Residence of Decedent		1400.0	ity. Town or L	casting						100	l Inalda Oil	n. 1 imita
	aryta athor		10a. Stete 10b. County	-1-1 4									100	d. Inside Cit	
	the Maryia 7 28a-1 show notified at	Director	PA Fran	nklin	W	aynesbo	10f. Zip (	ode.				10g. Citizen of \	What Countr		Λ-
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	100 P	nor a	11. Marital Status	12. Was	Decedent Ever in	U,S. 13.	Wes Decede	nt of Hi	spenic Ori	gin? (Sp	ecify Yes or N Rican, etc.)		ce - Americai		
0	or har	5	1 Never Married 2 ☐ Marri	d 1 1	ed Forces? Yes 2⊠ No					, Puerto	Rican, etc.)		ck, White, et		
21215-0020	5 48 4	2	3 ☐ Widowed 4 ☐ Divorced		s, Give or Dates:		1 □ Yes 2]	XJ No	Specify:			Specify	v: Whit	e	
5-0	72 h	Completed	15. Decedent (Specify only highes	s Education	ited)	16a. Dece	edent's Usuel kind of work DO NOT use	Occupa	ition fu <i>ring</i> mos	t of work	ing	16b. Kind of B	usiness/Indu	stry	
121	Party 1	du	Elementary/Secondary (0-12)	1	ge (1-4or 5+)			retired	)					15.0	
			17. Fether's Name (First, Middle, I	ast)		Pair	nter		18. Mothe	r's Name	e (First, Middle	Paintin , Maiden Sumen		racti	ing
lan	ad in the card of	90 0	Rick L. Kiser	,					Taw		Baker				
Maryland	M by	-	19e. Informent's Neme/Relationsh	ip (Type, Print)	ype, Print) 19b. Mailing Address (Street and Nu					-		per, City or Town,	Stete, Zip C	Code)	
S	27.10		Rick L. Kiser	avne	sboro	PA 172	68								
ore,	of He Mem		20a. Method of Disposition		20b.	Place of Disp cametery, cre	osition (Name	e of er place	a)		Date	20c. Location	City or Tow	n, State	
altimore	Pag International		1 □XBurial 2 □ Cremetion 4 □ Donation 5 □ Other (Sp		rom State P	rice's	Ch. C	emet	tery	N	ov 16	Waynesb	oro, I	PA	
alt	mit.		21. Signature of Funeral Servica L	icanses	BB	1 2	2. Name and	Addres	s of Fecilit	y Gro	ve-Bowe	ersox Fu	neral	Home,	Inc
00	88268		James A. Bo	versox	reall total	werkey 50	OS Bro	oad	ST	Wayn	esboro	PA 1726	8		
	Physician /Medical Examiner	9	Immediate Cause (Final disease or condition resulting in death)	a. NA	RCOTIC INTO	OXICATIO		ļ.						Onset end D	Jean .
	d ansit	Examine	Coquentially list conditions	b	Due to	(or es a conse	equence of):						1		
0			Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury												
3760,	9 % 9	2	that initiated events resulting in death) Last	c	Due to	(or as a conse	quenca of):								
x 68	certifica iding ph	N C		4											
Вох	daath o	100		<u> </u>									i		
o.	The law requires that the death certifice sate has been signed by the attending phy page 2 should be datached for use as the control of the sate of of the s	yar	Part II. Other significant condition	s contributing	to death but not re	sulting in the	underlying ca	use give	en in Pert t			tobacco use co		~	_
0	that the detail										1	Yes 2 No	3 Prob	ibly 4 KM	Unknown
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00	been si ahould	1010									perl	ormed?	com	lable prior to pletion of co eath?	ause
Re	Tha lay										·M	yes 2□No		Yes 2□	No
ta	sicien: The law cartificate has t lirector, page 2 a		25. Was case referred to medical						28 Place	of Doet	h (Check only		/5	100 20	140
of Vital	Physician: this cartific ral director.		examiner? 1 2 Yes 2 No	Hospitel:	1 ☐ inpatient 2	☐ ER/Outpatie	ent 3 DO/	Oth	or:		me 5 Res		ner (Specify)	at s	cene
0			27. Menner of Death	28e. [	Dete of Injury (Menth, Dey Year)	found?	of P 28	c. Injun	at k?		28d, Describe	how injury occur	rred		
Division	tal or Attending P rs after death. al Director: After t led in by the funera		1 Naturat 5 Pending	ation	11/12/00	2:13	3 M		Yes 2	No	diadiowii				
N	after death Director: A J in by the f		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	- (	Placa of Injury - At building, etc. (Spec		treet, fectory,	office			28f. Location City or To	(Street and Num. own, Stete) 1 Mo itehead Co	tel 6	Route Num	ber,
0	oltai oli illedii	2			nd: motel 1										Md.
	Hoep 24 ho Fune stely f	E Calca	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On t	o the best of my kr he basis of examin	nowledge, dee netion and/or in	th occurred e ovestigation, i	t the tim	ne, date en pinion, dea	id plece, ith occur	end due to the red at the time	cause(s) end m , dete and placa,	anner as sta and due to	ted. the cause(s	)
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	-	29b. Signature and title of certifier	9110	manner stated.		29c.	License	e number			29d. Date signe	ed (Month, D	ay, Year)	
	F 3 F 8			1	Un.	0.			M.E.			Novembe			
		-	30. Name and address of person v	to completed	sause of death (Ite									2000	
			mary		PLR, M.	-	11 Pen	n S	treet	, Ba	altimor	e, Maryl	and 2	1201	
	State		31. Date filed (Month, Day, Year)	1	32. Registrar's Sign		1 1	our	1/1						

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Wilbur George Kendall november 12,2000 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Hagerstown Washington Washington County Hospital Months Days Hours Min. April 1, 1904 6. Sax 1 X M 2 ☐ F 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 96 Yrs. 705-10-4693 Maryland Usual Rasidance of Dacedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Md. Washington Smiths burg 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 11208 Crystal Falls Dr. 21783 U.S.A 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Race - American Indien, Bleck, Whila, atc. Was Decedant of Hispanic Orlgin? (Specify Yes or No-II Yes, specify Cuben, Maxican, Puarto Ricen, atc.) 1 Yas 2 No Il Yes, Giva Yaar or Datas: 1 Navar Married 2 Marriad 1 ☐ Yas 2 ☐ No Specify. White Specify: 3 ☐Widowed 4 ☐ Divorced 16a. Decedani's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Railroad Machinist 10 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Amanda S. Cline Jesse J. Kendall 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Shirley M. Ryder (Daughter) 17901 Daisey Dr. Hagerstown, Md. 21740 20b. Placa of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 □ Cramation 3 □ Ramoval Irom Stata Smithsburg Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Smithsburg. Md. 21. Signetura of Funaral Sarvice Licensee 22. Nama end Addrass of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Congestive Heart Failure Immediata Cause (Final disease or condition rasulting in death) obstructure lung decase Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown quallonin 24b. Ware autopsy findings evelleble prior to complation of cause ol death? 24a. Was an autopsy performed? 2 9 No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

and

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Completed

Be

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Certification:

Medical

Alber

after death Director: /

To the Hospital of within 24 hours at To the Funeral D

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traur

**Physician** 

/Medical

**Examiner** 

Director

Funerai

by

Completed

**Funeral** 

Director

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal mast be notified at

2 should be filed within 72 hours after death is and Mental Hygiene. Is marked other than "natural", or items 234

Saltimore, Maryland 21215-0020

the Maryland

Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disaese or Injury that Initiated avants resulting in death) Lest physician a title burtal-Physician/Medical signed by the attending I

26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Residenca 6 Othar (Specify)

25. Was cesa rafarrad to medical axaminar? 1 Yas 2 40 27. Menner of Death

1 Watural

2 Accidant

3 ☐ Sulcide

1 ☐ Impatiant 2 ☐ ER/Outpatient 3 ☐ DOA 5 Panding invastigation

28b. Time of

28c. Injury et Work? 1 ☐ Yas 2 ☐ No

28d. Describe how Injury occurred

6 Could not be determined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 29a. Certifier 1 Contifying Physician: To tha best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

28f. Locallon (Straat and Number or Rural Routa Number, City or Town, Stata)

29b. Signalura and toll of certifiar

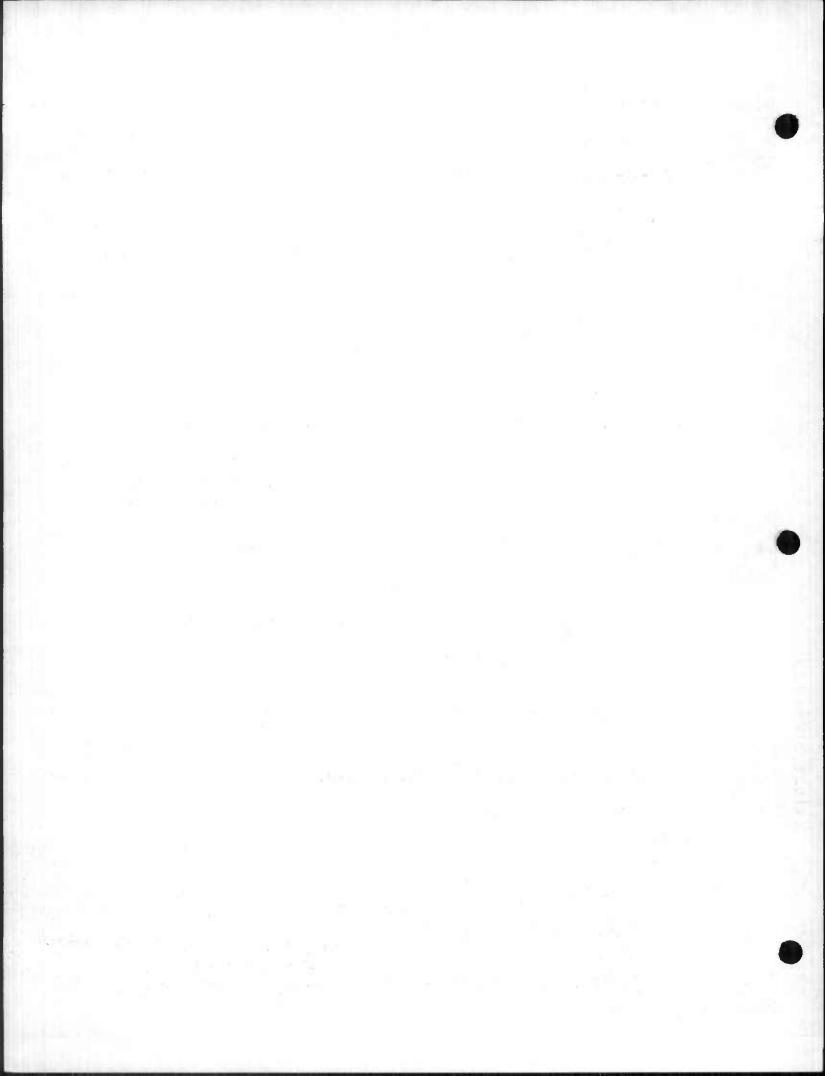
2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the causa(s) and mannar stated. 29c. License number 29d. Date signed (Month, Dey, Year)

M.D. on who completed causa of death (Item 23a) (Typa, Print) D0041131 338 min st.

State Registrar

31. Data filed (Month, Day, Year) NOV

stagers fown



State of Maryland / Department of Health and Mental Hygiene

							Cer	tificate of	Death		Reg. No.		, , , ,		
	Diam'r.	•	1. Decedent's Nama (First	it, Middla, La	est)					2. Data of I		Year	3. Time of Death		
	Physic /Medi		Kennet	h l	Eugene K	line				Novem		2000	7:00 PM		
<i>)</i>	Exami		4a. Facility Nama (If not in		The second second					, or Location of De	eth 4c. Coun	ty of Death			
	· ·		Washington						Hagers		)	ington			
	Funeral Director		5. Social Sacurity Numbe 213-40-4555 Usual Rasidance of Dace		Sex 7. As	ge (In yrs. last	Yrs.	Months Days		Min. 8. Deta of E (Month, OCt.	Birth Pay, Year) 12, 1940	9. Birthpiac Country Mary La	ca (Stete or Foreign and		
	yend we may		1	County		10c. City, To						10d	f. fnsida City Limits		
	Man H	to	MD Wa	shing	ton	Hag	ersto	wn					f⊡Yes 2□No		
	h the	irec	10e. Sireet and Number					10f. Zip Coda			10g. Citizen of What Country?				
	th will	<u>a</u>	750 Dual H	lwy.				21740			U. S. A.				
)20	72 hours after death with the Marylend natural, or items 23s or 28s-f show deal Examiner must be northed at	by Funeral Director	11. Maritel Status  1 Never Married 2 3 Widowed 4 D		12. Wes Decedent Armed Forcas?  1X Yes 2  If Yas, Giva Yaar or Datas:			Vas Dacedeni of l Yes, specify Cub □ Yas 2½ No		? (Specify Yas or I ruerto Ricen, etc.)		ece - Amarican ack, Whita, eld ify: White	c.		
0-0	72 hours natural',	Pe	15. [	ecedant's E	ducation		6a. Deced	ant's Usual Occu	pation		16b. Kind of I	Business/Indus	stry		
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/lar		To B	Floyd H. 1	Kline,	Sr.				Sarah	Virgini	a Renner	-			
, Maryland	d 2 ith er		19a. Informani's Name/R Charles Rob		,, ,			g Addraas (Straa N. Colon		or Rural Routa Num Hagers	town, MI		_		
ore			20a. Mathod of Dispositio			20b. Place	of Dispos	sition (Nama of atory or other pla	ice)	Data	20c. Location	- City or Towr	n, Stata		
Baltimore,	permit. Peges Department of i Important: If ite any injury or o		1 XBuriai 2 □ Cra 4 □ Donation 5 □ C					n Cemete		11/14/0	0 Hager	stown,	MD		
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			23a. Part I Enter the dis	ease, or com	pluations that cause	d tha daeth. D						A	oproximala		
	Physician		J. G. Hourt and	re. Clas Grily	77	it id.						Ö	ntarval Batween Onset and Death		
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on of	Ing	Certification:		Panding	28a. Data of Inju (Month, Da	y Year) 28t	o. Tima of Injury	28c. Inju			e how injury occu	irred			
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Division	is after death		4 Homicida	datamined	building, et	c. (Spacify)	, tarm, stra	at, factory, office			own, Stata)	iber of Aural A	todia ivamber,		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29a. Cartifiar 1 (Check only one)	ertifying Philedical Exar	ysfcian: To the bast niner: On the basis o end mennar st	f axamination	lga, daath end/or Inva	occurred at tha ti astigation, in my	ma, data and p opinion, death o	lace, and dua to the occurred et the time	a causa(s) and n e, date end place	nannar as state , and dua to th	ed. na ceusa(s)		
	within 2 To the comple	Me	29b. Signetuse and titla of	certifier				29c. Licen	se number		29d. Dala sign	ed (Month, De	ay, Year)		
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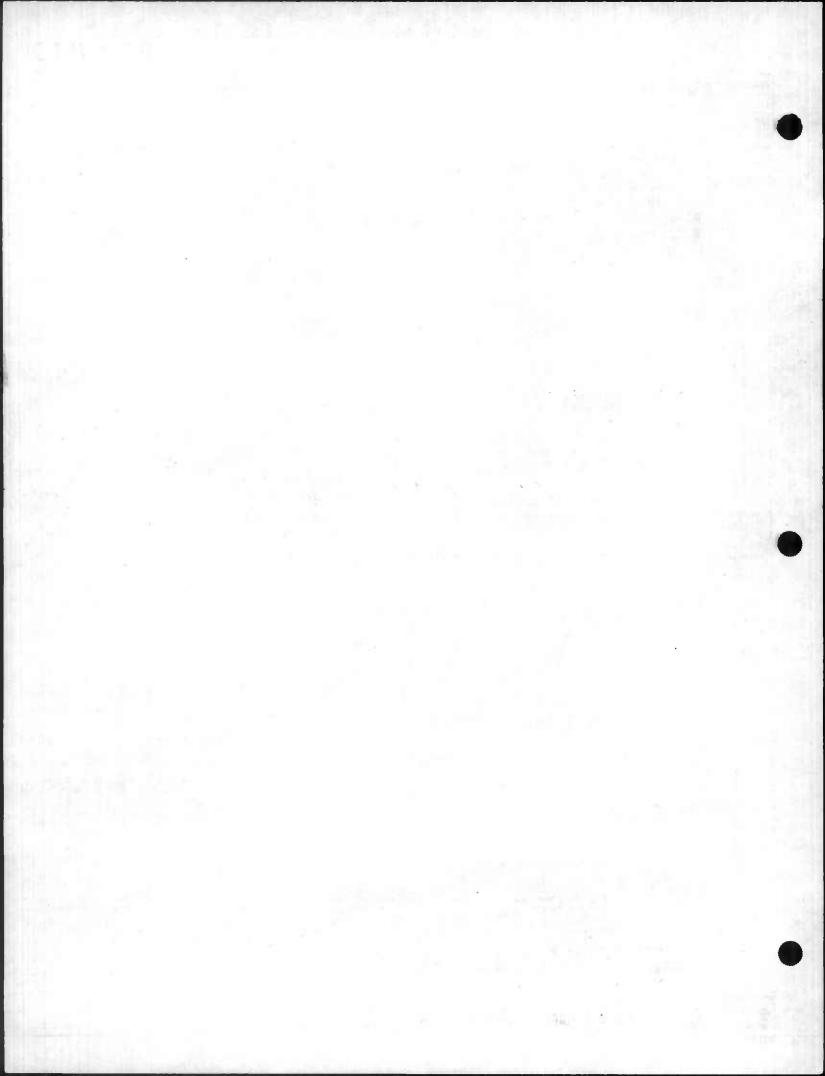
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State of Maryland / Department of Health and Mental Hygiene	00	3740	) (
Cortificate of Dooth			

	Certificate of Death	1	Reg. No.	71403					
Physician /Medical	Decedent's Nama (First, Middla, Last)	2. Dete of De	eth Day Year	3. Tima of Death					
	Helen Marie Linkous	NOVER	Cross Sylv	3:3200					
Examiner	4a Facility Nema (If not institution, give street and number)  4b. City, To	own, or Location of Deet	4c. County of Death						
	Doctor's Community Hospital Lanha	am	Prince Ge	orge's					
Funeral Director	Months Days Hours	Min. 8. Data of Bir (Month, Da	8. Data of Birth (Month, Day, Year) 9. Birthplaca Country)						
	5/9-30-2548	April	17, 1921 Wes						
	Usual Rasidence of Decedent  10a: Steta 10b: County 10c: City, Town or Location			10d. Inside City Limits					
rector	Maryland Prince George's Hyattsville			1 Yas 2 No					
Directo	10e. Street and Number 10f. Zip Code		10g. Citizan of What Cou	ntry?					
Funerai	4616 Burlington Road   20781	nigin? (Specify Yas or No	U.S.A.	can Indian,					
by Fur	Armed Forcas?  1 □ Nevar Marriad 2 □ Married  1 □ Yas 2 □ No  If Yas, specify Cuban, Maxica  1 □ Yas 2 □ No  If Yas, Giva  1 □ Yes 2 □ No  Specify  Year or Detes:		Rican, atc.)  Black, Whita, atc.  Specify: White						
	15 Decadent's Education 18e Decadent's Usual Occupation		16b. Kind of Businass/Ir	dustry					
Completed	(Specify only highast grade complated) (Giva kind of work dona during mo- Elementary/Secondary (0-12) Collega (1-4or 5+)	st of working							
E	12 Homemaker		Domestic						
Bec	17. Fathar's Name (First, Middla, Last) 18. Moth	nar's Nama (First, Middla	, Maidan Sumama)						
To	Hobart Garrett Cline Mab	el Susan Ra	nsom						
	19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Addrass (Street and Number)			o Code)					
	Shirley Brotherton - Daughter 4612 Burlington Ro	ad. Hvattsv	ille, MD 20	781					
	20e. Mathod of Disposition 20b. Place of Disposition (Nama of	Data	20c. Location - City or T	own, Stata					
	17 Burial 2 Cremation 3 Removel from State 4 Donation 5 State (Specify)  Fort Lincoln Cemetery	11/8/2000	Brentwood.	Maryland					
	21. Signature of Funeral Sendoe Licenses 22. Nama and Addrass of Facility	ity Gasch's F	uneral Home.	P.A.					
	4739 Baltimore								
	23e. Part: Entar the disease, or complications that caused the death. Do not enter the mode of dving, such as			Approximata					
n	shock, or heart failura. List only one cause on each line. Interval Between Onset end Death								
al	immediate Cause (Final BOWFE IS CHAPE	AMA							
r	Immediate Cause (Final disease or condition rasulting in death)  BOWFT (SCHFAMA  Dua to (or as a consequence of):  RUPTURFD MYCOTTC ANGURYSM								
Je .	Rupturan Mycoti	TC ANGE	RYSM						
edical Examiner		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
Ä	Sequantially list conditions, if any, laading to immediate causa. Entar Undarlying Causa (Diseasa or injury  c.								
dica	that initiated evants rasulting in death) Last Dua to (or as a consequence of):								
-	d.								
lan	U								
/slc	Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part	l. 23b. Did	23b. Did tobacco use contribute to the cause of dea						
Ph	AND STARE RENAL DISTASE	10	Yes 20 No 3 □ Pro	obably 4 Unknow					
by	10			/ara sutopsy findings					
Completed by Physician/N	O EMENTIA		ormed? 8	vailable prior to					
npi			0	omplation of causa daath?					
ribis certificate has b rral director, page 2 s 1; To Be Compli		1 🗆	Yas 2 No 1	☐ Yes 2☐ No					
Be	axaminar?	ca of Death (Check only	ona)						
10	1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 N		dence 6 Othar (Spec	ify)					
on:	27. Mannar of Death 1 \$\overline{A}\$ 28a. Data of Injury 28b. Tima of Injury 28b. Tima of Injury 28b. Tima of Injury 28b. Tima of Work?  28d. Data of Injury 28b. Tima of Work?								
Certification:	2 Accidant invastigation M 1 Yas 2 No								
E	3 Sulcide 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata)								
2									
edical	29a. Certifier (Check only one)  1 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data a mannar stated.  2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, da and mannar stated.	and place, and dua to the tath occurred at the time,	data and placa, and dua	to tha cause(s)					
Medical Certification: 1									
	10421	1042149 1116/00							
	29b. Signatura and titla of pertilling 29d. Data signed (Month, Day, Year)  29c. Licanse number 29d. Data signed (Month, Day, Year)  11/6/00  30. Name end addrass of person who completed causa of daath (Itam 23a) (Type, Print)  RAYMOND 0 NW ADIUKU, MD 9831 SRAWBECT DD 87E 101 CAN AAM MO 2070								
	RAYMOND O. NW ADIUKO, MD 9831 BRAINBLE	T GD STE	WELL OUTS	1 402070					
State	31. Date filed (Month, Day, Year) 32. Registrar's Signatura								
istrar	NOV 0 7 2000 Serve B. Son No								

DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death De Month Yeer Lewis NOVEMBER 01, 11:36 A.M. 2000 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 02-07-1924 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign 1X M 2□ F Months Deys Hours Washington,DC Yrs. Prince George's Capitor Heights 10d. inside City Limits 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of Whet Country? 20743 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ∑XYes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, While, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Administrative Assistant Private 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Augustine 19e. Informent's Name/Relationship (Type, Print) Vivian E. Young/Sister 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 905 Sitka Lane, Capital Hgts, Maryland 20743 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 11/14/00 Cheltenham, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Ceme. 22. Name end Address of Fecility
J.B. Jenkins Funeral Home 21. Signeture of Juneral Service Licensel 7474 Landover Road, Landover, Maryland 20785 7474 Landover Road, L Approximete Interval Between Onset and Deeth MYOCARDIAL INFARCTION 20 MINUTES Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigetion 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated.

P.O. Box 68760 Division of Vital Records,

death certificate be executed physician and s the buriel-transit signed by the a has certificate this After Attending death. ector: after 6 Hospital 24 hours

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

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Examine

Physician/Medical

g

Completed

Be

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Certification:

edical

80 950 Po

page 2

director

funeral

3

James

**Funeral** 

Director

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"natural", or items 23s or adical Examiner must be

Pages 1 end 2 should be filed within 72 hours after a nent of Heatth end Mental tyglene. Int: If ferr 27 is marked other than "natural", or fter Iny or other traumalte event, the Medical Examine Iny or other traumalte event, the Medical Examine

permit. Page Department of Important: If any injury or pace.

**Physician** /Medical

Examine

Baltimore, Maryland 21215-0020

the Maryland

death with

James

5. Social Security Number

Usuel Residence of Deceden

905 Sitka Lane

Elementary/Secondary (0-12)

20e. Method of Disposition

Immediate Cause (Finel

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest

1 Yes 2 No

27. Manner of Deeth

1 Naturel

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifier

disease or condition resulting In deeth)

Lewis

577-86-2992

10e. Street end Number

lary Land

11. Maritel Stetus

To the I 6

31. Date file State

and eddress of person who completed cause of death (Item 23e) (Type, Print) 89 MDG/1050 W. PERIMETER RD. JACQUELYN H. SALAS, MAJ, USAF, MC

#2. Registrer's Signeture

ANDREWS AIR FORCE BASE, MD 20762-6600

29c. License number

6081548

29d. Date signed (Month, Dey, Year)

NOVEMBER 01, 2000

Registrar

G 081548 MDG/1050 W. TWS AIR F¢

cyland

_and 20885

20 ?

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Dela of Deeth 1. Decedent's Neme (First, Middle, Last) 3 Time of Death Month NOURMBER -UCILLE -EE 0304 a.m 2,000 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street and number) 4c. County of Death MEDICAL SYSTEM | BALTIMOST MARYLAND Birthplece (State or Foreign Country) 5. Social Security Number 8. Dala of Birth (Month, Day, Year) Months Days Hours 1□ M 2⊠ F 220-26-1427 Usuel Rasidence of Decedent Yrs Feb. 18, 1930 MARYLAND 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARMAND I Dorchester 10g. Citizan of What Country? 5848 hardson Rd USA 21631 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indian, Black, White, etc. 11. Merital Status 1 ☐ Yes 2 MNo If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yas 2 PNo 3 ☐ Widowed 4 ☐ Divorced Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 hickens 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Marcells DOCKINS oung Willian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 5848 Richardson Rd. EAST New Market, 21631
Dete 20c. Location - City or Town, State Lillan Dockins Hughes/Sister

Hygiene. other than "natural", or flems 23a or 28a-f show ent, me Medical Examiner must be notified at Saltimore, Maryland 21215-0020 and 2 should be fit of the alth and Mental H the new 27 is marked off or other traumatic aven Pages nent of h Department Department Important: I any Injury o

**Physician** 

/Medical

Examiner

10a. State

20e. Method of Disposition

Immediate Ceuse (Final

diseese or condition resulting in death)

1 █ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stele

4 ☐ Donation 5 ☐ Other (Specify)

21. Signeture of Funeral Service Cicenses

23a Part T. Enter the diagram or con shock, or heart fallule. List only

Funeral Director

λq

Be Completed

**Funeral** 

Director

**Physician** /Medical

Examiner

Be

Physician/Medical Examiner Completed by

To the Hospital or Atlanding Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director.

P.O. Division of Vital Records.

State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseesa or injury that initiated events resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case raterred to medical examiner? Medical Certification: To

27. Manner of Death Natural 2 Accident 3 Suicide

1 Yes 20 No

4 - Homicide

29a Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s)

6 Could not be datermined

28a. Dete of Injury (Month, Day Year) 5 Pending invastigation

end manner stated.

28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

Hospitel: 2 ER/Outpatient 3 DOA

28b. Tima of

20b. Pleca of Disposition (Name of cemetery, crematory or other place)

EPSIS

Due to (or es e consequence of):

Due to (or as e consequence of)

Due to (or as a consequence of)

EASTNEW Market Cem.

22. Neme end Address of Facility

Do not antar tha mode of dying, such es cardiac or respiretory errest,

28c. Injury el Work? 1 Yes 2 No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

24a. Was an autopsy performed?

1 Tyas

28d. Describe how Injury occurred

20 No

9/2000

Bennie Smith Funeral Home 426 Dorer Street, EASTON, Mary land 21601

FAST New Market, Md.

Approximate Intervel Between Onset and Deeth

MONTH

29c. License number 12443

BALTEMORE

29d. Date signed (Month, Day, Year) NOUTMBER

2120

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were eutopsy findings available prior to completion of cause of daeth?

1 Yes 2 No

M-D 30. Name end address of person who completed cause of daeth (Item 23a) (Type, Print)

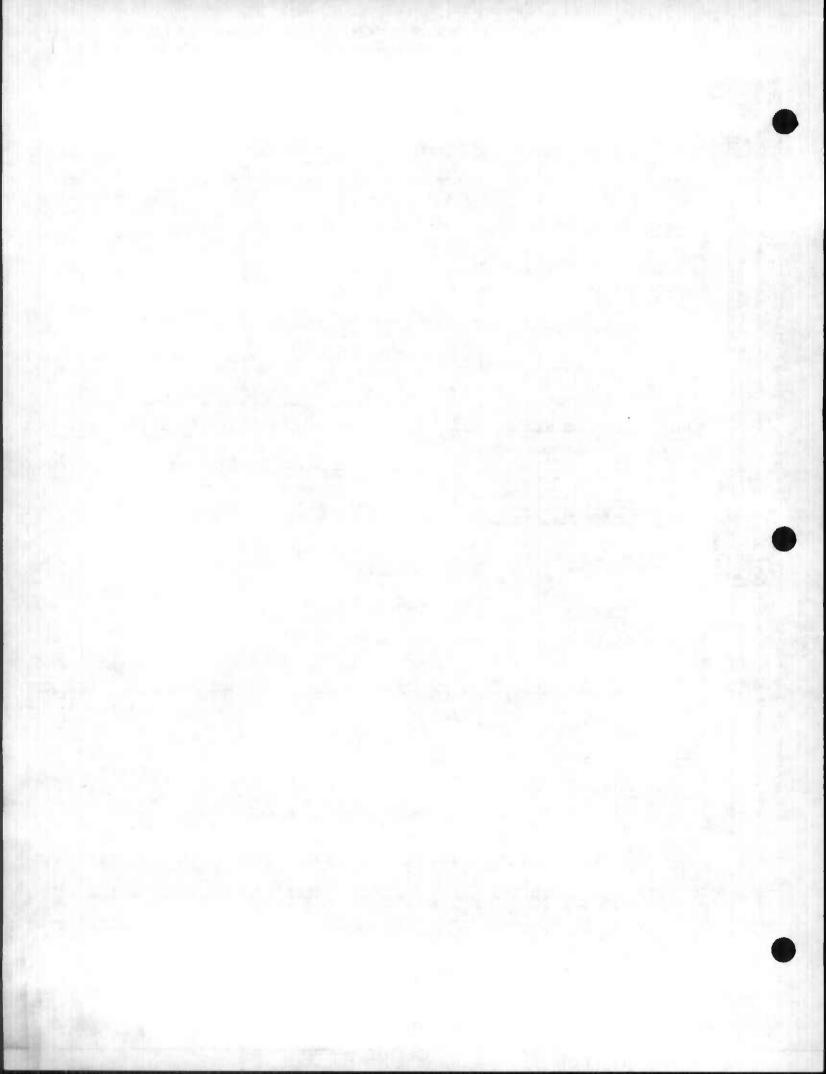
29.5. BENJAMIN LOWENTRYTHAD 32. Registrar's Signature

31. Data filed (Month, Day, Year)

29b. Signeture and title of certifier

boath

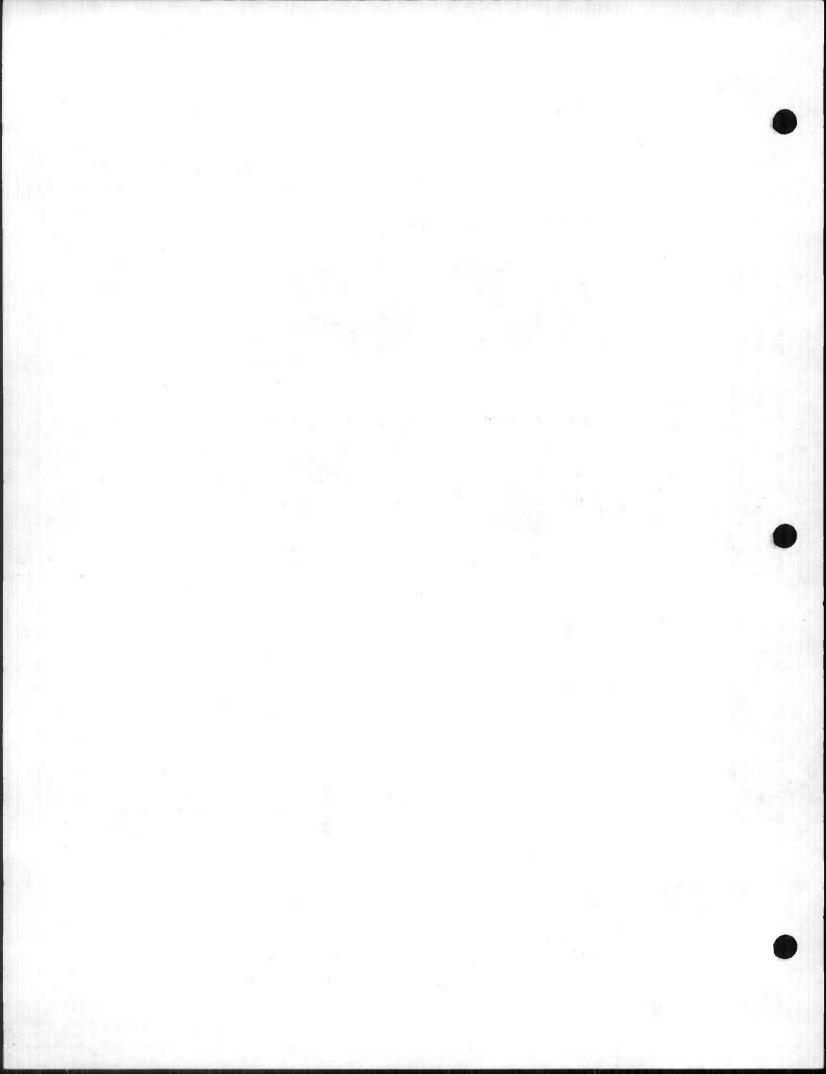
DHMH 16 Rev 6/95 **ORIGINAL** 



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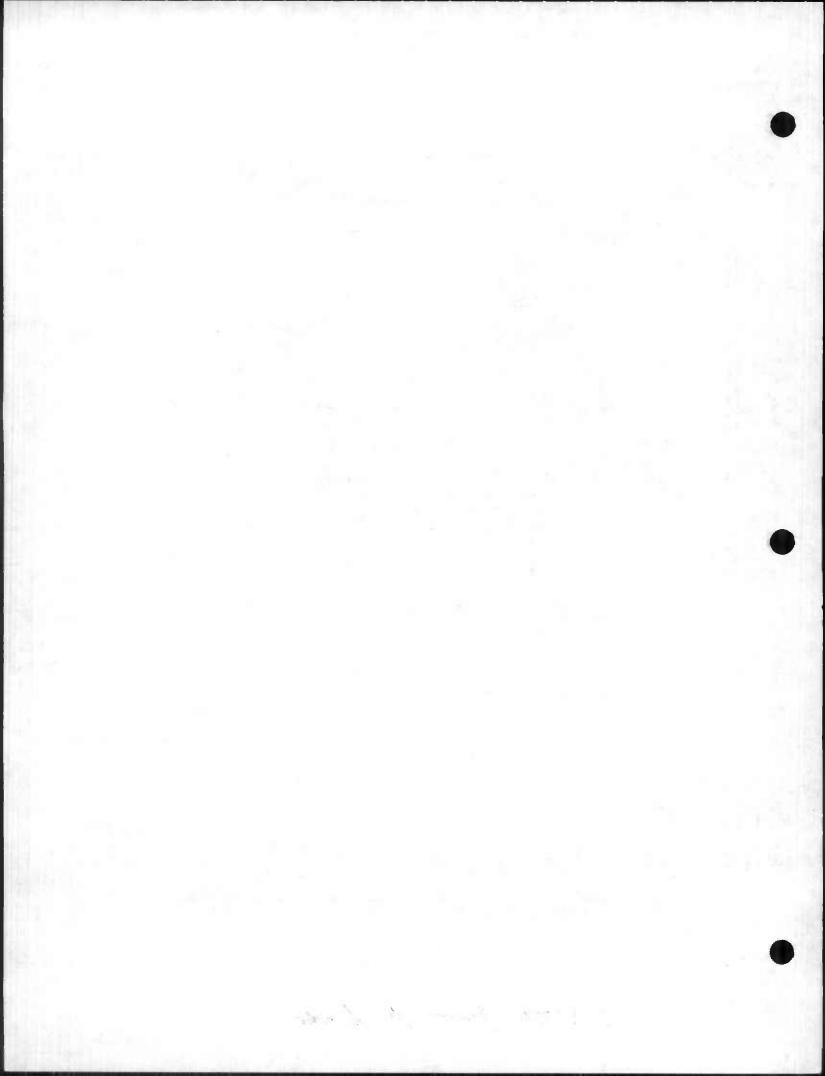
State of Maryland / Department of Health and Mental Hygiene 1 2 7 4 2

	1 Decedent's Name (First Middle	f act)	(	Certificate	e of i	Death		Reg. No.		2 Time of Death
Physician	1. Decedent's Nema (First, Middle, Last)  MADY HOLTETT I AME						2. Dete of De Month	Dey	Yeer	3. Time of Deeth 5:10 AM
/Medical Examiner		MARY HOWELL LANE 4e Fecility Neme (If not institution, give street and number)				NOVEMBER 7, 2000 5:  4b. City, Town, or Location of Death 4c. County of Death				J. IV AII
	CAROLINE NURSING HOME					DENTON		CARO		
Funeral Director	5. Social Security Number  220-03-3523  Usuel Residence of Decedent	220-03-3523			1 Yaar Deys	If Under 24 Hrs. Hours Min.				ace (State or Foreign try) ID
how	10a. Steta 10b. County							7.70	10	Od. Inside City Limits
vith the Mer or 28s-1 si be notified Director	MD TALB	TALBOT EASTON								XX Yes 2 □ No
or 2	10e. Street end Number				10f. Zip Code			10g. Citizen of What Country?		
ath w	414 AUGUST ST.				21601			USA r No- 14. Race - American Indien,		
d within 72 hours effer death with the Manyland dwithin 72 hours effer death with the Manyland glene. It has hadical Examinar must be notified at completed by Funeral Director.	3 XWidowed 4 ☐ Divorced	Armed Forces?		13. Was Deceded If Yes, special 1 Yes 2		ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	Specify	k, White, e	etc.
led within 72 hot ygjene. The the matural it, ne wedjest	15. Decedent's (Specify only highest	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of work		ing	16b. Kind of Bu	b. Kind of Business/Industry		
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be filled d other event, b	17. Father's Neme (First, Middle, L					18. Mother's Nem	eme (First, Middle, Maiden Surnama)			
ould be filed with Mental Hygiene.  Triked other than aftic event, the H	The state of the s						ISE PENDRELL			
d 2 should be file th and Mental Hy 7 is marked othe traumatic event	19e. Informent's Neme/Relationsh	p (Type, Print)	19b. I	Mailing Address	(Street	and Number or Rur	ural Route Number, City or Town, State, Zip Code)			
C, such a Health a sm 27 is when train	MARIE L. BRADL		4	14 AUGUS	ST S	T. EASTON	N. MD 21	601		
Pages nent of int: If th	20e. Method of Disposition  1 🖾 Buriel 2 Cremetion  4 Donetion 5 Other (Sp.	☐Removel from State	20b. Plece of I cemetery	Disposition (Nem cremetory or of WN MEMOR	e of her plea	e)	Dete	20c. Location - EASTON		m, State
permit. Pages Department of Important: If it any injury or o	21. Signature of Funeral Surviva Licensee  22. Name and Address of Facility  FELLOWS, HELFENBAIN & NEWNAM FUNERAL HOME PA  200 S. HARRISON ST EASTON, MD 21601									
Physician /Medical	shock, or heart failure. List only one cause on each line.									Approximete Interval Between Onset and Death
Examiner	resulting In deeth)		Que to (or es e co	ensequence of):		0				43
ificate be executed g physician and as the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	b	Due to (or es e consequence of):							
	thet initiated events resulting in death) Lest	■ d	Due to (or es a co	nsequence of):						
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requires that the deeth cert requires that the deeth cert hould be deteched for use.										ebly 4 Unknow
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ath. r: Afterne fune	27. Mannar of Deeth  1. Naturel 5 Pending 2 Accident investige	tion				y et k? Yes 2 □ No	28d. Describe how injury occurred			
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To the within To the comple	29b. Signeture and title of certifier	11/					29d. Date signed (Month, Day, Year)			
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	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)									
	WAFIK ZAKI,			DENTON	, MI	21629				
State Registrar	31. Dete filed (Month, Day, Year) NOV 0 8 2000	32. Registro	er's Signetura	brav.	,					



State of Maryland / Department of Health and Mental Hygiene 00 374

			Ce	rtificate of	Death	Reg	J. No.	3/4/3		
Dhuniainn	Decedent's Name (First, Middle, Last)					Date of Death     Month Day Year  3. Time of Death     Year				
Examine	ROBERT LEE LYLES					Novembe	er 13,	2000 11:00		
	4a Facility Name (If not institution, giv				4b. City, Town, or Lo	cation of Deeth	4c. County of	Death		
	2108 Belltree				Waldors			rles		
List after death with the Maryland If, or terms 23e or 28ed show Caminer, must be notified at by Furneral Director	5. Social Security Number 577–68–7999	Monthe Dave House Min /M			8. Date of Birth (Month, Dey, ) JUNE 27,	1946 N	Birthplece (State or Fon Country) MARYLAND			
	Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or L	ocation				10d. inside City Lin		
	MARYLAND CHARLES	TATA.	TOOPE					1XXYes 2□		
	MARYLAND CHARLES WALDORF  10e. Street and Number 10f. Zip Code					10g. Citizen of What Country?				
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Man "	Elementery/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	CHARLES				
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To To	WILLIAM WRIGHT LYLES  MARY HELL  19a. Informant's Neme/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Pura					EN JONES LYLES				
and the second	CATHERINE LYLES /					LDORF, MARYLAND 20601				
Han offers	20a. Method of Disposition	20b.	. Plece of Disp	osition (Neme of		Date 20	Oc. Location - C	ity or Town, State		
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spart y inj	21. Signature of Funeral Service Licer	1500 + O. h	2	2. Name end Addre	ess of Facility FUNERAL H	OME DA				
0528	LADIA C. THORN	TON JOHNSON M	Lange of the land					, MARYLAND 2		
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sician end burial-transit	Sequentially list conditions, if any, leading to immediate	Due to (or es a consequence of):								
	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury									
g physicie es the bu	thet initiated events pue to (or es e consequence of): resulting in death) Last									
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ed by the ettendin detached for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.					23b. Did tobacco use contribute to the cause		ribute to the cause of de		
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should be det						24e. Wes en	autopsy ed?	24b. Were autopsy finding available prior to		
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entifica octor, p Be C	25. Wes case referred to medical		Carlo		26. Place of Deat	h (Check only one	)			
his certificate had director, page	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA Ot	hor	me KResider		(Specify)		
2 2	27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inju	ry at	28d. Describe hov	v injury occurre	d		
leeth. tor: After th the funeral cation:	1 X Nakiral 5 Pending investigation		Injury Work?  M 1 Yes 2 No							
within 24 hours after deeth.  To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not b	be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rurel Route Nur City or Town, Stete)					r or Rurel Route Number,			
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	29a. Certifier tale Control one)  29a. Certifier tale Control one)  2 Medical Example one)	nysician: To the best of my kinniner: On the basis of examinand manner stated.	nowledge, dee nation and/or is	th occurred at the ti nvestigation, in my o	me, dete and plece, opinion, deeth occur	end due to the cer red et the time, dat	use(s) and man te end plece, ar	ner es stated. nd due to the cause(s)		
New Within	29b. Signeture end title of certifier		0	29c. Licens	se number	29	d. Date signed	(Month, Dey, Year)		
N C O	1 House	MA	Vin=	D	28352	No	ovembe	r 14,2000		
	30. Name and eddress of person who	completed cause of death (It	em 23a) (Type			140	. volide.	11/2000		
	Krishan Mathu				La Plata	A. MD	20646			
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Sig		1 1	_ ~	-, 2				
Registrar	NOV 15	2000 Seren	~ 6	. door	the					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: #5 PER F.H. G790 12-8-00 WR. of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18, 2000 **Physician** Delia Elizabeth Loomis November 10:10 pm /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rock Glen Nursing and Rehab Baltimore N/A If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yeer) 12 May 15, 1912 If Under 1 Yaar 7. Aga (In yrs. lest birthday) 9. Birthplaca (Stata or Foreign **Funeral** Days Min. Hours 1 □ M 2 1 F Mary Land 01-2912 88 Yrs. Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours effer deeth with the Marylan tent of Heelth and Mantal Hygiens, it is filem 23 and 28e-f shown if it fem 27 is marked other than "naturel", or items 23a or 28e-f shown inty or other traumatic event, 25e Magdian Examine must be nother inty or other traumatic event. 1 ☐ Yes 2 No Directo Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 #7 Gwynn Lake Drive United States Funeral Was Decedant Evar in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Raca - Amarican Indian, Black, White, atc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Nevar Marriad 2 ☐ Married 21215-0020 1 Yes 2 No Specify: Specify: white þ 3℃Vidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) UNKNOWN Collage (1-4or 5+) Homemaker own home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Edgar K. Sheiblein Julia Foulke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville, Maryland Susan Neville / daughter 25 Newburg Ave. 21228 20b. Place of Disposition (Name of cematary, crematory or other pleca) Nov.22 20c. Location - City or Town, State 20a. Method of Disposition 1 B Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If eny injury or once. Louden Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Baltimore, Maryland 21. Signature of Funeral Servica Licensee 22. Nama and Addrass of Facility Harry H. Witzke's Family Funeral Home, Inc. Spolon 4112 Old Columbia Pike Ellicott City, MD. 21043 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heart tailura. List only one cause on each line. **Physician** CEREBRO VASCULAR ACCEDENT /Medical Immediata Causa (Final disaasa or condition resulting in daath) **Examiner** Due to (or as a consequenca ot):

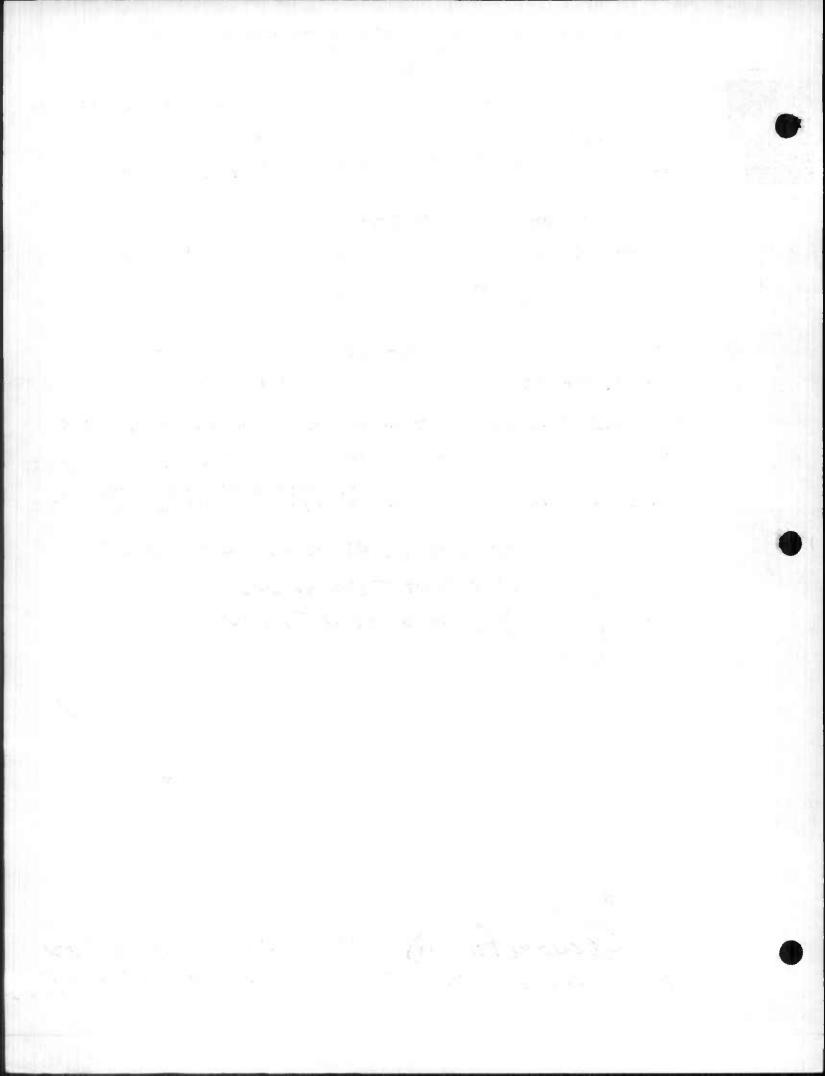
YPENTENS/ON iclan end bunal-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaase or Injury that initiated events resulting in daath) Last P.O. Box 68760. Physician/Medical Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by been signe should be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Viital Hospital or Attending Physician: Be 25. Was case retarred to medical examiner? 26. Placa ot Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 412 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To 1 Yes 2 No Division of After this 27. Mannar ot Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural death. 1 Yes 2 No 2 Accident ofter deat Director: 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28t. Location (Street end Number or Rurel Routa Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours e-To the Funerel C 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, date and placa, and dua to tha cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiar Medical 29b. Signature and title of certitier 29d. Date signed (Month, Dey, Yeer) 29c. Licansa numbar ed cause of death (Item 23a) (Type, Print)

WORE

2. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #26.Per Phys.PGC 11-7-2000 cr 2. Dete of Deeth 1. Decedent'a Neme (First, Middle, Last) 3. Time of Death Yesi James Leroy Moulden 1506 UDL 2000 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth ANNAPOLIS OBer ourt If Under 24 Hrs. If Under 1 Yeer 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) 11–15–1932 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 1₩ 2□ F Montha Deys Hours Min 217-28-7985 Yrs Maryland Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Prince George's Bowie 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 20720 12106 Lanham Seven Rd. U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 200 No If Yes, Give Year or Dates: Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) County Elementery/Secondary (0-12) 7th College (1-4or 5+) Custodian Government 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Richard Moulden Irene Harrison 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Shirley D. Moulden/Wife 12106 Lanham Seven Rd. Bowie, MD 20720 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 11-4-00 Riverdale Crematory Riverdale, MD 21. Signature of Funeral Servica Licange 22. Name end Address of Fecility J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785 inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onaet end Deeth Arterioscleratic Heart Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hhknown 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one)

**Physician** /Medical Examiner

certificate be executed

Division of Vital Records, P.O. Box 68760,

Attending

ò Hospital 24 hours

efter deetl Director:

To the To the To the P

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Medicai

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

Be

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, it is the other traumatic event, it is the other traumatic event.

Baltimore, Maryland 21215-0020

physician and the buriel-transit 50 use a for signed by the a page 2 has certificate this funeral After r deeth.

Examiner Physician/Medicai by Completed Be 10 Certification:

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Neturel

5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 - Homicide

28e. Dete of Injury (Month, Day Year) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home (Specify) Residence 28c. Injury et Work? 1 Tyes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier

29a. Certifie

(Check only one)

eputy in

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29d. Date signed (Month, Day, Year)

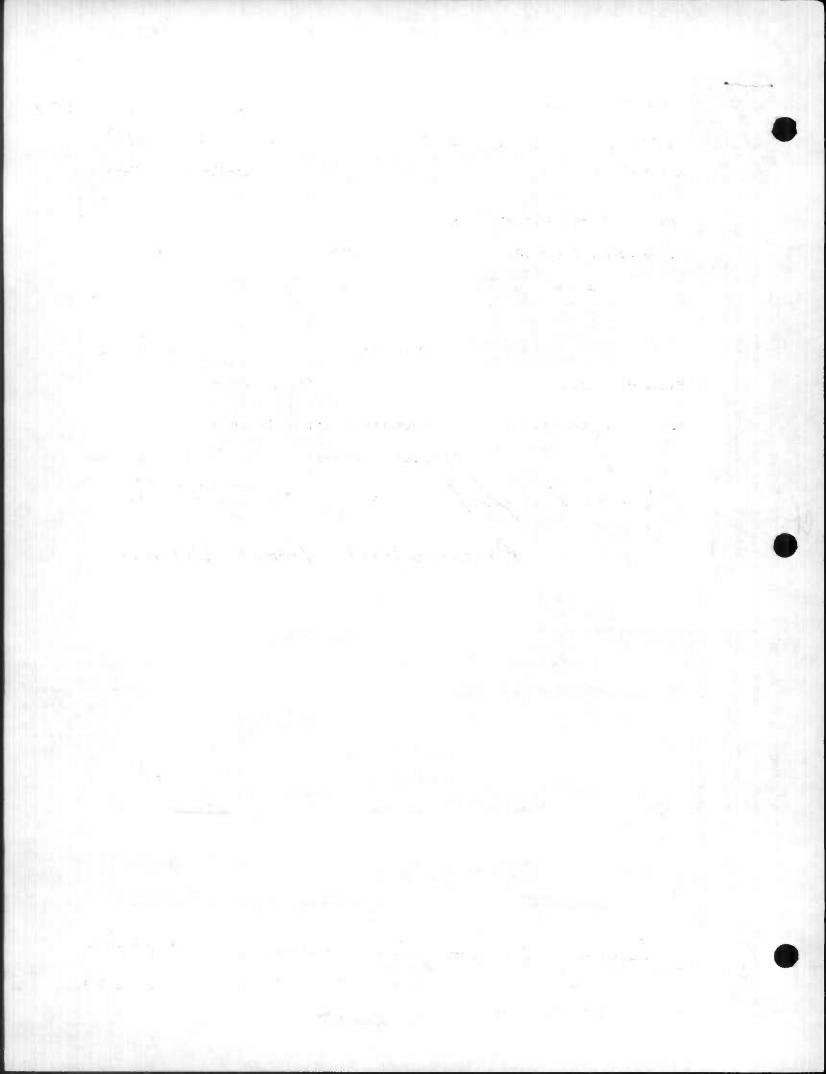
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) ou D 1/1/Am ONY5

695 America 21035

Registrar

31. Dete filed (Month, Dey, Year) NOV 0 7 2000





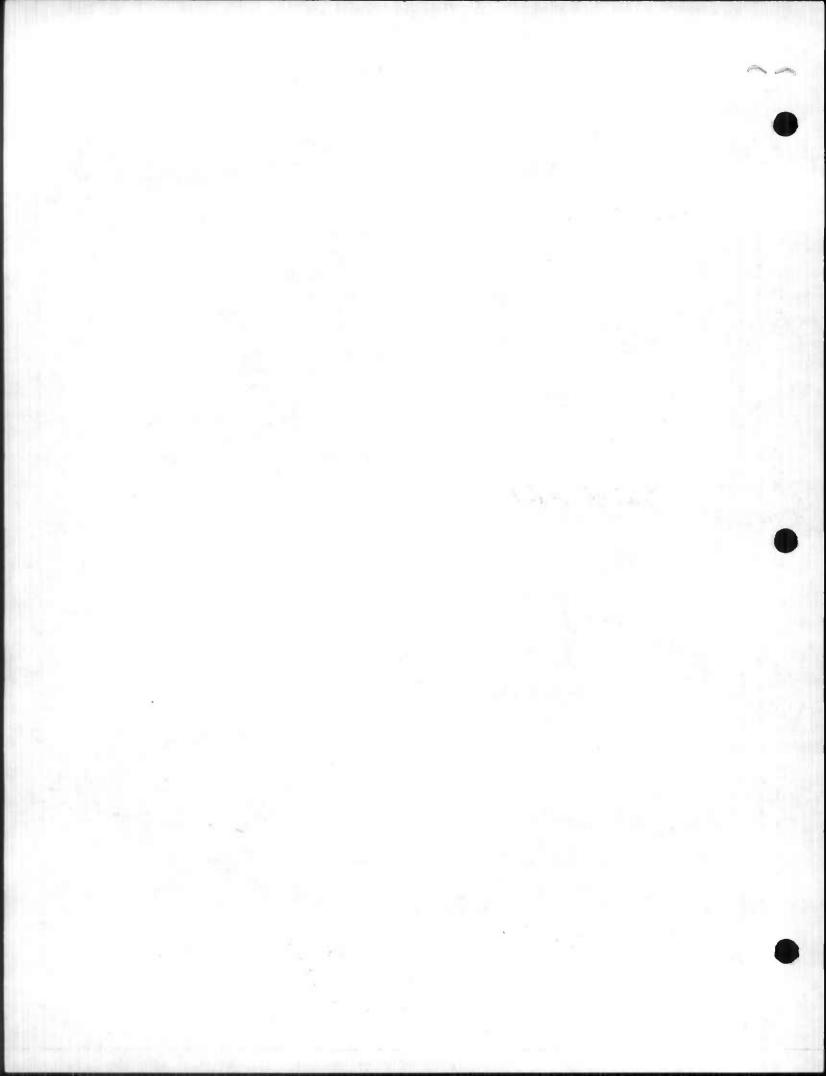
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 31, 2000 Rita J. Moore **Physician** October 5:19 AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8910 Erie Ave North Beach Calvert County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Director July 15, 1938 Washington DC 220 34 2635 Usuel Residence of Decedent the Maryland 10a. State arol ina 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at 1 ☐ Yes 2X No Director North Carteret Morehead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 West Haven Blvd. 28557 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZZNo If Yes, Give Year or Detes: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental hygiene.
Intelf from 27 is marked other than "naturel, or its my or other traumats event, the Mandal Emmin any or other traumats event, the Mandal Emmin 1 Never Merried XX Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify. by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 At Home Homemaker 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumame) 8 Madeline A. Mark 10 Udell S. Barnes 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 28557 19e. Informent's Neme/Reletionship (Type, Print) 908 West Haven Blvd., Morehead City, North Carolina Robert H. Moore , Sr. (HUSBAND) 20a. Method of Disposition

AZ Burial 2 Cremation 3 Removel from Stete 20b. Place of Disposition (Name of cemetery, cremetory or other p Date 20c. Location - City or Town, State Fort Lincoln Cemetery Nov 3,2000 permit. Page Department of Important: if any Injury or once. Brentwood, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 Norus X 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical System Lymphony Nevous Examine Due to (or as a consequence of): Examiner physician and the buriel-transit that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) - esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. signed by i 1 Yes 2 No 3 Probably 4 Unknown þ The law requires 24b. Were autopsy tindings evailable prior to completion of cause of deeth? Completed 24a. Was an eutopsy performed? page 2 1 ☐ Yes 2 ØNo 1 ☐ Yes 2 ☐ No Division of Vital 8 25. Wes case reterred to medicat examiner? 26. Place of Deeth (Check only one) San 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Posterie 27, Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Naturel Attending. 5 Pending death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident after deatl Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lowenthal, M.D. 110 Hospital Road, Suite 310, Prince Frederick, MD20678 31. Date filed (Month Den Year) 32-Begistrar's Signature State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day November 5, **Physician** 2000 1:00 a.m. Nellie Theresa Mullen /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's If Under 24 Hrs. Hours Min. II Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1□M 20 F Months 215-44-7991 84 March 26, 1916 Washington, DC Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limita r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20906 U.S.A. 2921 North Leisure World Blvd. #302 13. Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yea, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 th end Mental Hygiena. 7 le marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Payroll Supervisor Federal Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If fem 27 ie marked othe any injury or other traumatic event, page. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Charles Mullen Nellie E. Flaherty 19b. Mailing Addreas (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty Rohrbaugh - Niece 854 Clubhouse Village View, Annapolis, MD 21401 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Wivet Cemetery 11/09/00 Washington, DC Mount 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21. Signature of Funeral Service License 4739 Baltimore Avenue, Hyattsville, MD 20781 23a PartT. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be assected Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vitai Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of) attending p S 980 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. signed by t 1 Yes 2 No 3 Probably 4 Unknown by should b 24b. Were sutopsy findinga available prior to 24a. Was an eutopsy performed? Completed completion of cause of death? has le 2 page 2 No 1 ☐ Yes 2 ☐ No 1 Yea certificete Physicien: Be 25. Wes case referred to medical 28. Place of Death (Check only one) Hospital: Other: ANursing Home 5 Residence 8 Other (Specify) 1 Yes No 2 1 Inpatient 2 ER/Outpetient 3 DOA After this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28c. tnjury at Work? or Attending 1 Natural 2 Accident 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No Director: / 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled **Descripting Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) and manner as stated.

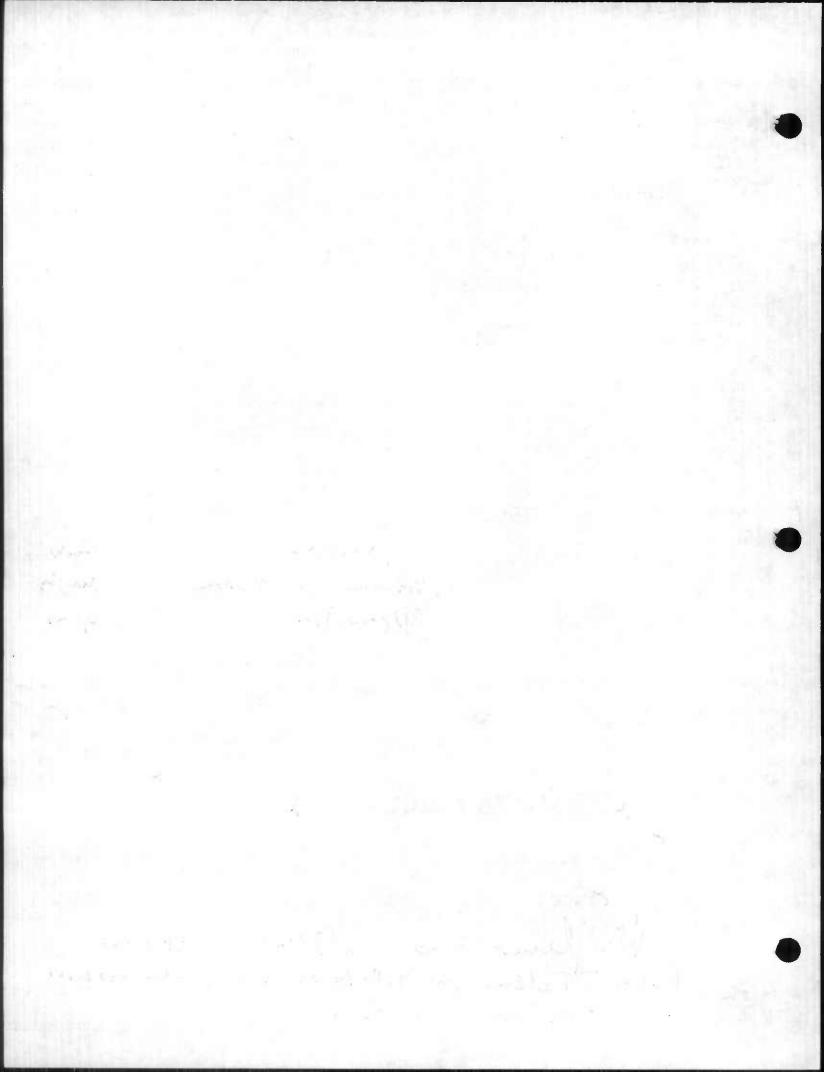
**Description: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner ateted. edical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signa on who completed cause of death (Item 23a) (Type, Rrint) 30 Name and address of p sous al

State

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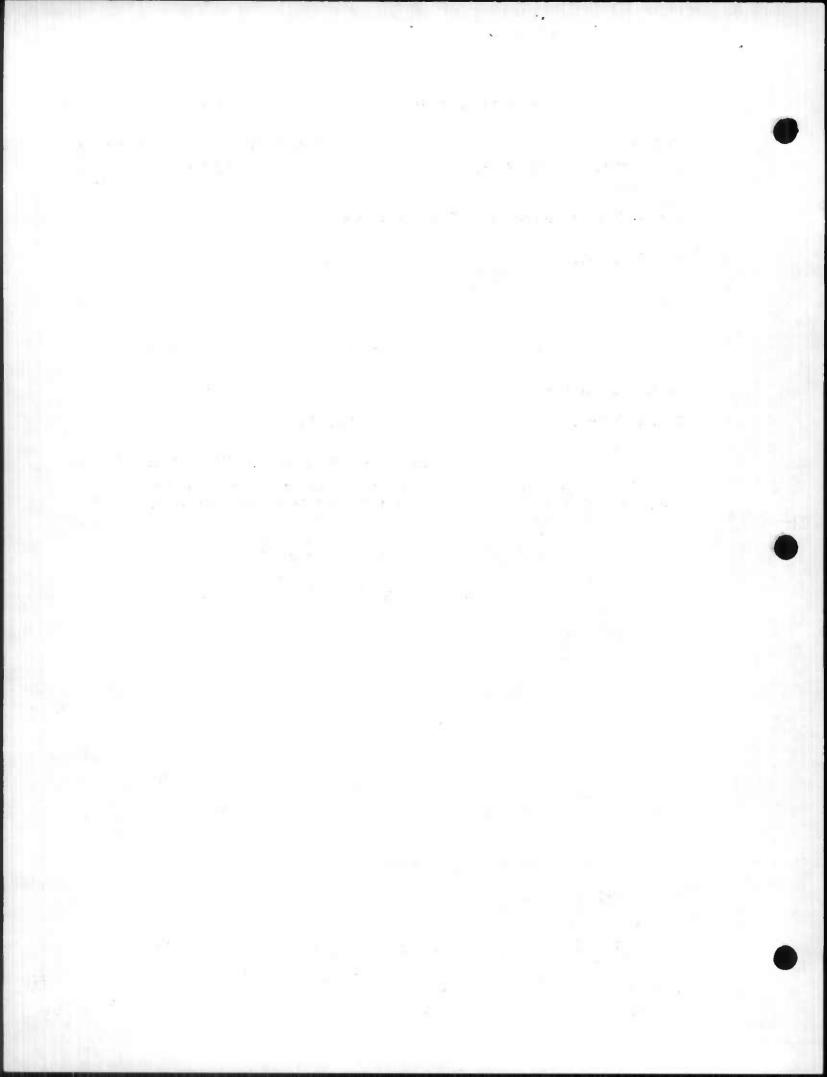
31. Date tiled (Month, Day, Year)

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	Certificate of	f Death	Reg	J. No.	
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erti	4 Homicide  3 Suicide  4 Homicide  4 Homicide  4 See. Pleas of Injury - At home, ferm, street, fectory, offi building, etc. (Specify)		City or Town,	Stete)	
edicai Certification:	29a. Certifier Cartifying Physician: To the best of my knowledge, deeth occurred at the	time, date end plece. e	and due to the cau	use(s) end menner es	stated.
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)	30, Name end eddress of person who completed cause of death (Item 23a) (Type, Print)	) , ,	2 1 11	C1 1	1 1 1
/	DEVARA L. VARNER, MD/11701 LIV	angoton 6	Kd.#10	17; H. 1	ashiration
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Registrar



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Dete of Death 3. Time of Deeth Dey 2000 **Physician** 6:35.Pm matthews Mossett NOV /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Springdale 9107 residence TayLor st Prince George If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yis, lest birthday) If Under 1 Yeer Months Deys Birthplece (State or Foreign Country) **Funeral** 246-24-271 Yrs. Director Mar. 26, 1921 N.C. Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or lients 23s or 28s-f show the Medical Exeminer must be notified at the Maryla Springdale 1 ☐ Yes 2 No Prince George Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S. A Ноти 23а 9107 Tay 20774 1105 Funeral 11. Maritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 Never Merried 2 Merried 1□ Yes 2 No þ Specify: 18 lack 3 Widowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) S. Govt. Iruck Driver 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) h and Mental I should be marked hillie moody I matthews Herring (Dang) J9b. Mailing Address (Street end Number or Rural Route Nymber, City or 107 Taylor St Spr. Ng dalle 19e. Informent's Name/Reletionship (Type, Print) n, Stole, Zip Gode) GNG 20774 Pages 1 and 2 of Health f Nem 27 i Helen London-Benfield Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Department of Important: If It 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 9 11/19/2000 Landover Md Harmony 4 Donetion 5 Dother (Specify) 22. Name ord Address of Fecility Phillip Bell Funeral Service 21. Signature of Funerel Service Licenses Elis Bell 4902 Stan Haven Ratemple Hills Md 20748 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medicai TERMINIAL LUNG Examiner Due to (or as a consequence of) Examine MALNUTRITION The law requires that the deeth certificate be executed physician and s the buriel-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): for use es signed by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown CHRONIC LYMPHATIC LEVICE MIA þ 24b. Were autopsy findings avellable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed HYPER TENSION s certificate has b director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, p. 25. Wes case referred to medical examiner? 28. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Maturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hour. The Funeral Direction of the filled in To the Hosp within 24 hou To the Fune completely fil edical 29a, Certifier 🗠 certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner steted. 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) Master Sough my 11/06/00 DO50514

6570 ICRNICWORTH AVE Suite 2100. Riverdale, MAD.

20737.

State Registrar 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

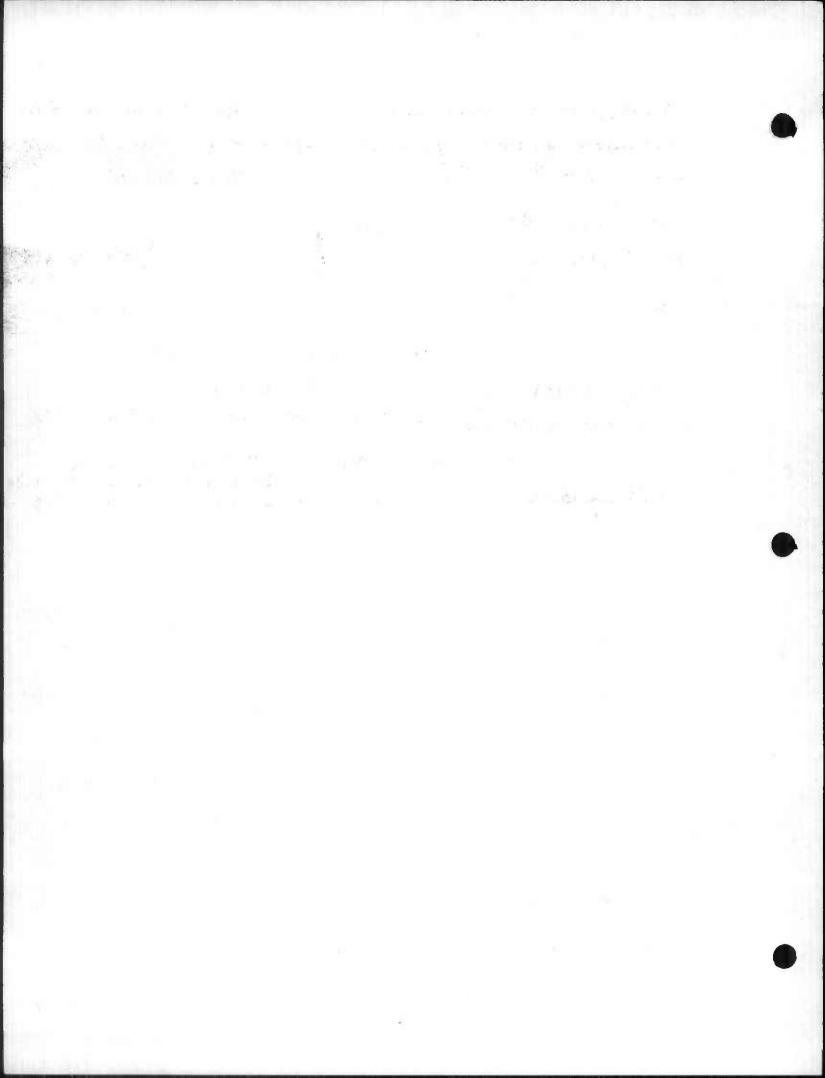
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32. Registrar's Signeture

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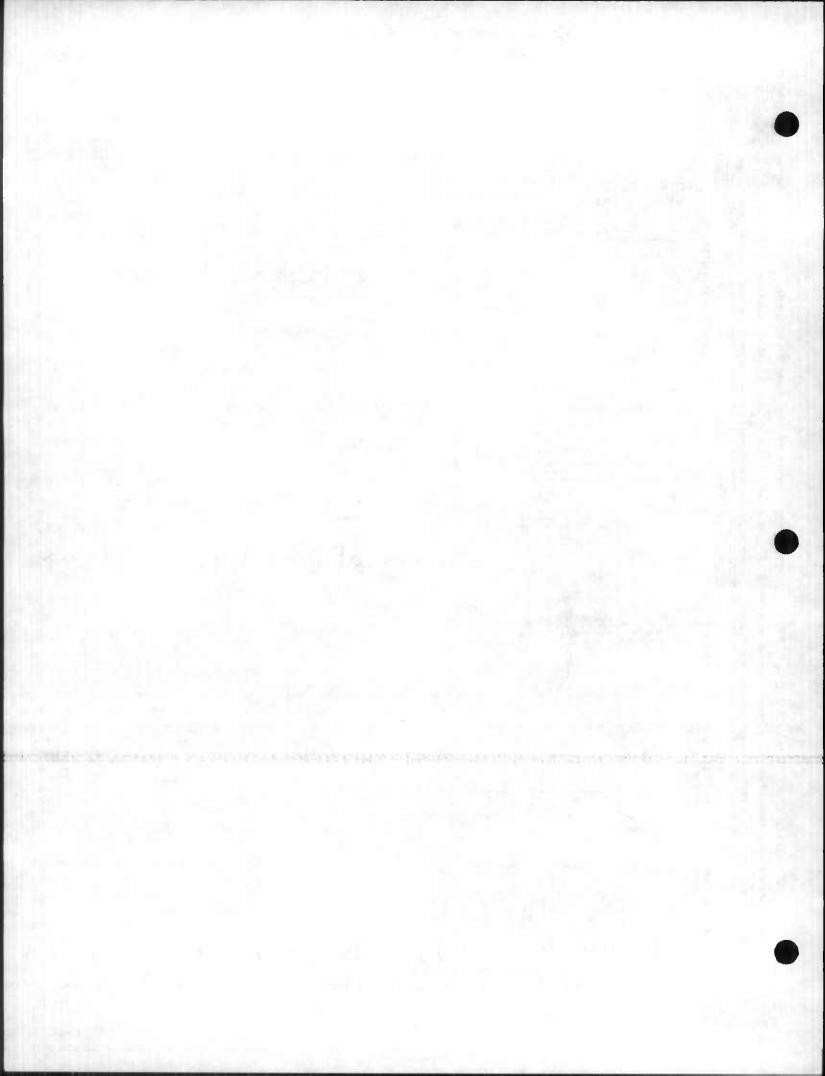
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State of Maryland / Department of Health and Mental Hygiene 00 37420

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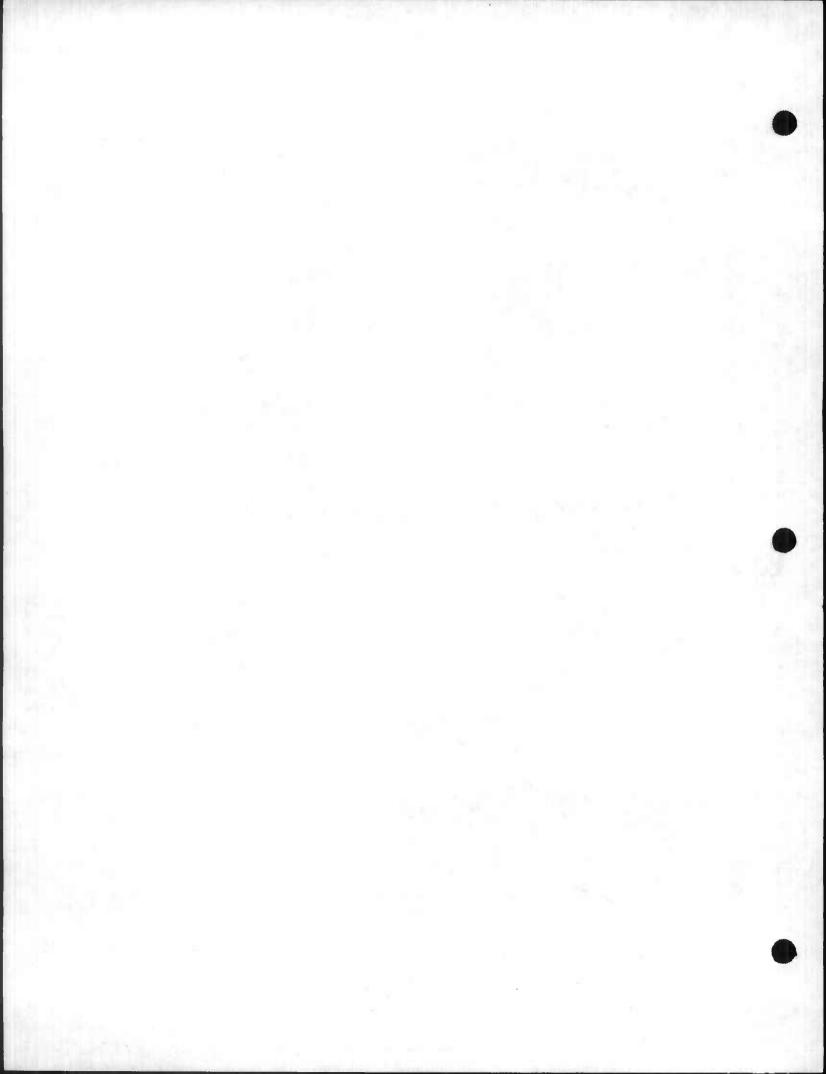


### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 37421

Physician	1. Decedent's Name (First, Middle, Last	Death	Reg. No.  2. Dete of Death Month Dev Yeer  3. Time of Death Yeer							
/Medical	CHARLES HOWARD MC	CAULEY				Month		Yeer 2 03 53		
Examiner	4a Facility Neme (If not Institution, give Washington County				ib. City, Town, or Li Hagers		4c. County of Washin			
Funeral Director	5. Social Security Number 6. Se 212-24-6889	X 7. Age (	(In yrs. lest birthdey) 72 Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey,	⁷ 1928	9. Birthpleca (Stete or F		
N III	Usuel Residence of Decedant 10a. State 10b. County	1	10c. City, Town or Lo	ocation				10d. Inside City		
er er	Maryland Washi	ngton		H	lagerstown	n		1 ☐ Yes 2		
23e or 28e-1 show unit be morthed at ral Director	10e. Street end Number 12021 Belvedere R	oad		10f. Zip Code	21742	1	10g. Citizen of What Country? USA			
or hems parameter by Fune	11. Meritel Status  1 Nevar Merriad 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U,S. 13.	Was Decedent of H If Yes, specify Cube			- American Indien, White, etc. White			
- 4 -	15. Decedant's Edu (Specify only highest gred Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Dece (Give lifa.	dent's Usuel Occup kind of work done DO NOT use retired	ation during most of work f) viceman	ring	Gas C	iness/industry		
d off H	17. Father's Nema (First, Middla, Last) Howard Lee McCaul	ey		002	18. Mother's Nam	e (First, Middle, M	Meiden Sumeme,			
PEE	19e. Informent's Neme/Reletionship (T)	ype, Print)	19b. Mailir	ng Addrass (Street	end Number or Rui	rel Route Number	City or Town, S	iteta, Zip Code)		
saith e	Mildred A. McCaul	ey, Wife			edere Road			Maryland 21		
nent of He int: If them iny or oth	20a. Method of Disposition  1 □ Buriel ②Chremetion 3 □ F  4 □ Donetion 5 □ Other (Specify)			osition (Nama of metory or other plea ourg Crema		Date OV. 13		city or Town, Stete Ourg, Maryl		
Departm Importa any inju	21. Signature of Funerel Service Licens	7			A. Fiery			Maryland 2		
physician and strength and stre	Immediata Causa (Final diseasa or condition resulting in death)  Sequentially list conditions, if any, laeding to immediate	b	SANO ue to (or es a consec ue to (or es e consec	quence of):	W IS			Longs		
g physicia as the bur ledical	Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	C. Du	ue to (or es e conseq	quenca of):		-		1		
g physicia as the bur ledical	resulting in death) Last	d			en in Pert I.	23b. Did to	bacco uae cont	iribute to the cause of		
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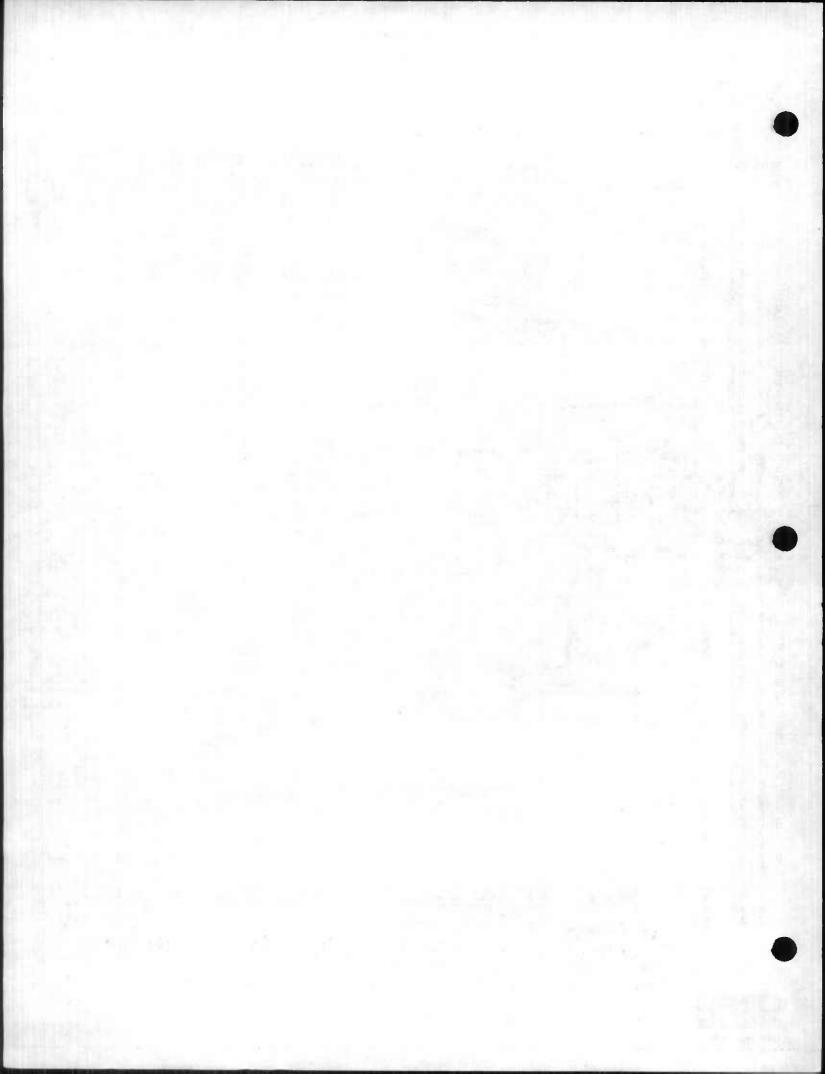
McCoolog, Charles Ameral



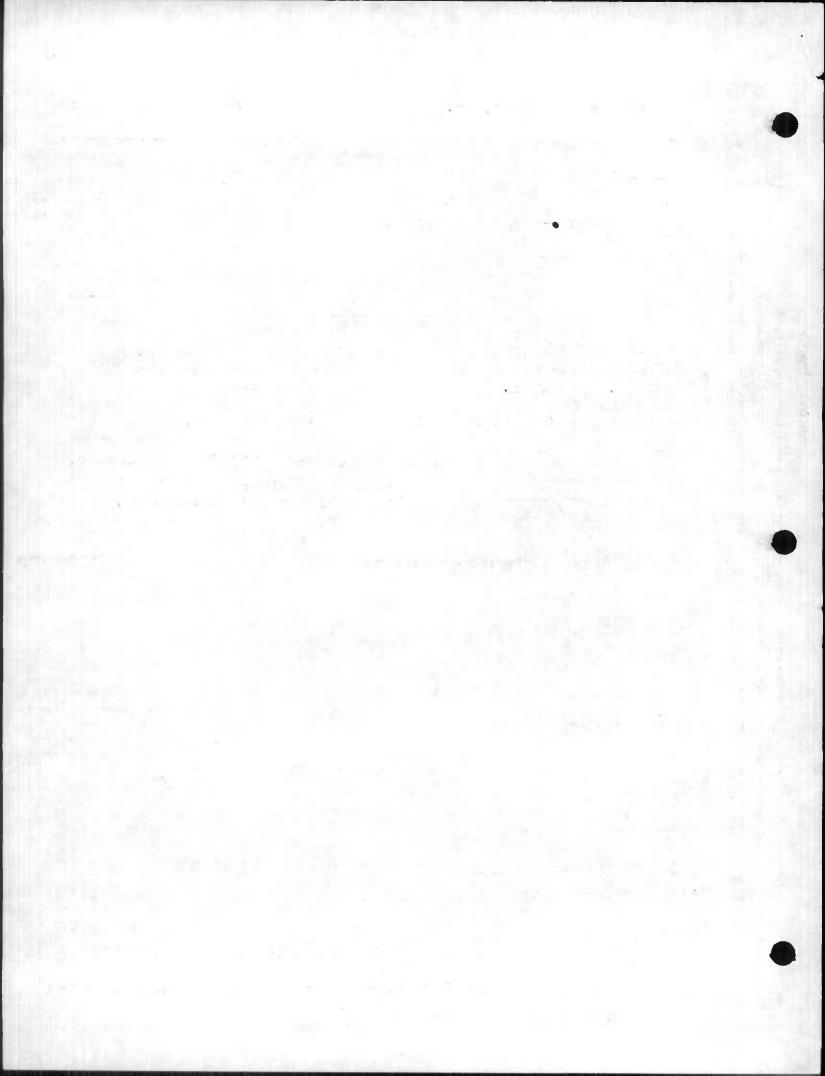
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	Certificate of Death	Reg. No.	7 1 4 6. 6.
Physician	DODOTUV MAS MADINE	2. Dete of Deeth  Month  Dey  Year	3. Time of Death
/Medical Examiner	4a Facility Nema (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER 4b. City, Town, or Local SALISBURY	OCTOBER 31 200 ation of Death 4c. County of Dea WICOMI	
Funeral Director	213-22-2584 13 M 25 1 7 3 Yrs.		thplaca (State or Foreign ountry) Lryland
with the Maryland a or 28a-f show be notified at Director	Usuel Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   Rhodesdale	e	10d. Inside City Limits 1 ☐ Yes 2/C)(No
or 28s-f s or 28s-f s be notified	10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Co	ountry?
23a c	5204 Brookview Street 21659	United St	
5-UUZU 72 hours after death v 72 hours or thems 23 deal Examiner must	11. Marital Status  12. Was Decedent Evar In U,S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Evar In U,S. Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:	ify Yes or No- ican, etc.)  14. Race - Ame Bleck, White  Specify:	
21215-0 ed within 72 ha viglene. er than fratur f. the Medical.	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired)	16b. Kind of Business	/Industry
willhain sens the Man	Elementery/Secondery (0-12) College (1-4or 5+)  8  College (1-4or 5+)  Nurses Aide	Nursing	
	AT THE WAY OF THE COURT AND A STATE AS A STA	First, Middle, Maiden Sumeme)	
ylanc cuid be fi Mental H white swer			
Man district	19e. Informent's Neme/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural is South Street and Number or Rural		
Office of the search of the se	20e. Method of Disposition 20b. Place of Disposition (Name of	Dete 20c. Location - City or	
Pages nent of 1		1/3 Rhodesdal	e, MD
Ball permit Depart import any in	21. Signature of Funeral Service Licensee  22. Name end Address of Fecility  Framptom-Hawkins- PO Box 43, Federa	alshura MD 21	Home, PA
	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or shock, or heart feilure. List only one ceuse on aech line.	respiretory errest,	Approximete Interval Between Onset and Death
Physician / /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting In deeth)  Due to (or es e consequence of):		2 days
P # E	Due to (till es a consequence oi).		
ox/60, cate be executed physician and s the buriel-transit edical Examine	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause, (Disease or Injury C.		
	resulting In death) Last  Dua to (or as a consequence of):		
BOX ( Beth certif attending for use a		1 000 00000	
by the	Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.	23b. Did tobacco uss contribut	s to the causs of death?  Probably 4 Unknown
by bed by	On gestine heart failine		
The law requires that The law requires that tale has been signed i page 2 should be del Completed by P	schrodima.	24a. Wes an autopsy performed?	Were autopsy findings eveileble prior to completion of causa of deeth?
= - 40 0		1□ Yes 2X No	1□Yes 20 No
Of VITAL IN Physician: The this certificate ral director, page TO Be Co	25. Wes case referred to medical 26. Place of Deeth (examiner? Hospital: No. 2774)		anife)
T will be	1 2 inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home	e 5 ☐ Residance 6 ☐ Other (Sp. Bd. Describe how injury occurred	eciry)
DIVISION C ball or Attanding P is after death. al Director: After the ed in by the funers Certification:	3 Sulcide 6 Could not be determined 28e. Pteca of Injury - At home, ferm, street, factory, office builting, etc. (Specify)	Bf. Location (Street and Number or F City or Town, Stete)	Rural Route Number,
Hospi 14 hour Funer tely fill	29e. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, en (Check only one)  1 Medical Examiner: On the besis of axamination end/or investigation, in my opinion, deeth occurred and menner stelled.	nd due to the ceuse(s) and manner and at the tima, dete and place, and du	as stated. se to the cause(s)
To the within 2 To the comple	296. Signalure and title of certifier and title of certifier D. Wernich, M.D. 29c. Licanse number D 15384	29d. Date signed (Mor	oth, Day, Year)
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)	ALISBURY MI	21804
State Registrar	31. Dete filled (Month, Day, Year)  32. Registrer's Signeture		

DHMH 16 Rev 6/95



/sician					Certificate	UI Dealii		Reg. No.		
/sician		me (First, Middle, L		-			2. Dete of De Month		2000	3. Time of Death 4:56an
ledical			d Myers,				Nov			4:50an
miner		The Art of the State of	ive street and number	)			or Location of Deat	4c. County	of Deeth	Harford
	-	lyden Co		4	idhday) If Under 1	Falls Yeer   If Under 24 H			11 01 0	
	5. Social Security		Sex 7. A	ge (In yrs. last b			in. 8. Dete of Bir (Month, Pa Jun 4	1930	9. Birthpi Coun	lace (State or Foreig try) MD
	213-24- Usual Residence		der	70	110.		Jun 4	1930	-	MD
	10a. Sfete	10b. County	TCA	10c. City, Tov	vn or Location				10	0d. Inside City Limit
lor	MD	Transfer	Harford	Fo	llston					1 ☐ Yes X X N
9	10e. Street and N	lumber	with CA	ra.	10f. Zip C	ode		10g. Citizen of V	What Coun	fry?
Funeral Director	210h H	Iyden Co	nnt.		2	1047		USA		
	11. Merital Stetus	-	12. Wes Decedent	Ever in U,S.		of of Hispanic Origin? Cuban, Mexicen, Pu	(Specify Yes or No	- 14. Rec	e - Americ	
	1 Never Ma	arried 2 Married	Armed Forces X12 Yes 2 If Yes, Give Yeer or Dates:			Cuban, Mexicen, Pu	erto Rican, etc.)	Specify	ck, White, o	etc. hite
		15. Decedent's E		168	. Decedent's Usual	Occupation	NO.	16b. Kind of B	usiness/Inc	dustry
		condary (0-12)	rade completed) Coltege (1-4or	541	life. DO NOT use	done during most of a retired)	vorking			
	11		Conlege (1 46)		Salesman	/Manager		Goody	ear	
	17. Father's Nam	e (First, Middle, Las	st)				lame (First, Middle	, Meiden Sumen	10)	
	Harold	E. Myer	s, Sr.			Alma	Peck			
		Name/Relationship				Street and Number or				
	Pamela	Brandau	/daughte	r 2	104 Hyde	n Court	Fallsto	n, MD	2104	1
	20e. Method of D	•		comet	of Disposition (Neme	of er plece)	Dete	20c. Location -	City or To	wn, State
		2 ☐ Cremetion 3 ☐ 5 ☐ Other (Spec	☐Removel from State :ify)		dow Bran	ch Cem	11/6/0	0 West	mins	ter, MD
	21. Signature of f	Funeral Service Lice	ense		22. Name and	Address of Facility Funeral	Tioma	nd Cho	201	
ı	1 -	11	/			shington				MD 2115
	23a. Part1. Ente	the disease, or con	mplications that cause y one cause on each	d the death. Do					,	Approximate
	shock, or ne	eart failure. List onf	y one ceuse on each	iine.					1	Onset and Death  1 Day
	Immediate Cause diseese or condit	tion	- from	9/6	Ailure	HYPOXEMI	A		-	4 mont
	resulting in deeth	1)		Due to (or as a	consequence of):					
Examiner			b			END STAG	E RENAL FAI	LURE	1	4 Months
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	cause Enter Un	derlying or Injury	C			HYPERTEN	SION			10 Years
	Cause (Disease			Due to (or as a	Due to (or as a consequence of):				i	
Ö	Cause (Disease that initiated ever resulting in death	nis								
	that initiated ever	nis	d							
	resulting in death	nts n) Last								
	resulting in death	nts n) Last	dcontributing to death	but not resulting	in the underlying ceu	se given In Part I.			1	the cause of deat
	resulting in death  Pert II. Other sign	nis (a) Last		but not resulting	in the underlying ceu	ise given in Part I.		tobacco use co Yes 2□ No	ontribute to	
	resulting in death  Pert II. Other sign	nts n) Last		but not resulting	in the underlying ceu	ise given in Part I.	1	Yes 2□ No	3 Prol	bably 4 Unkno
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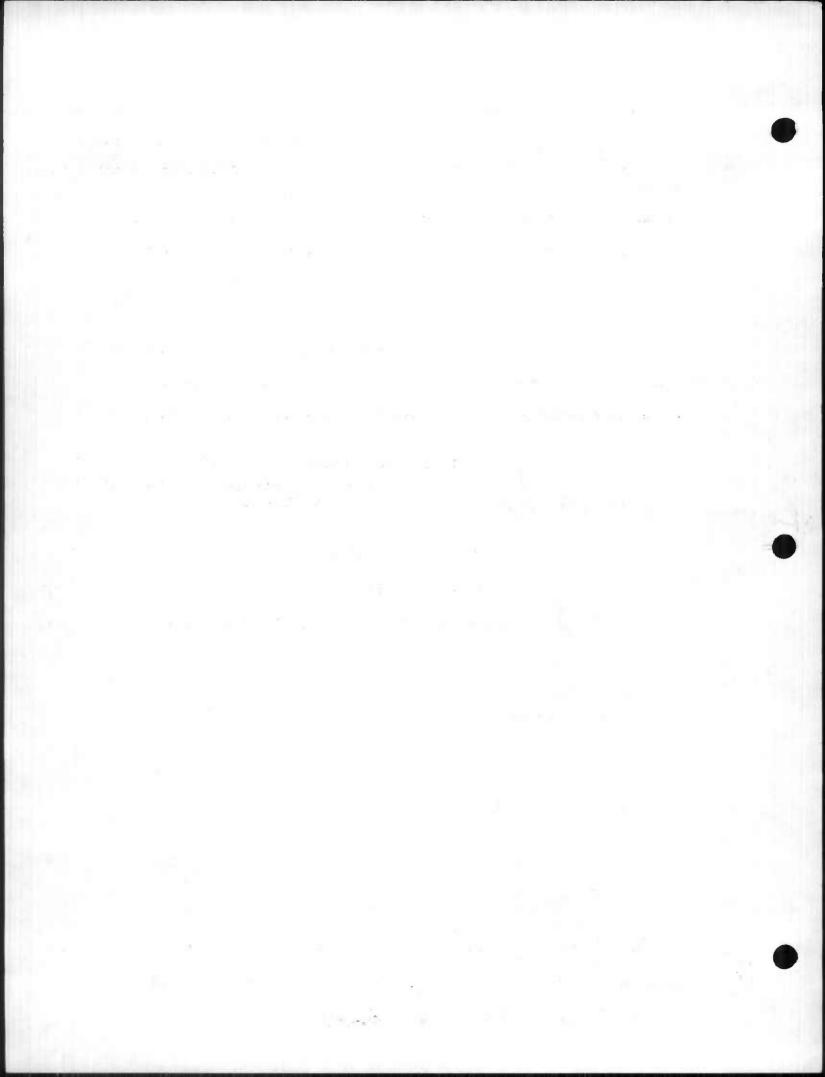


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		d of Disposition			20b. Place of Disp	position (Name of		Date	20c. Location -		m, State
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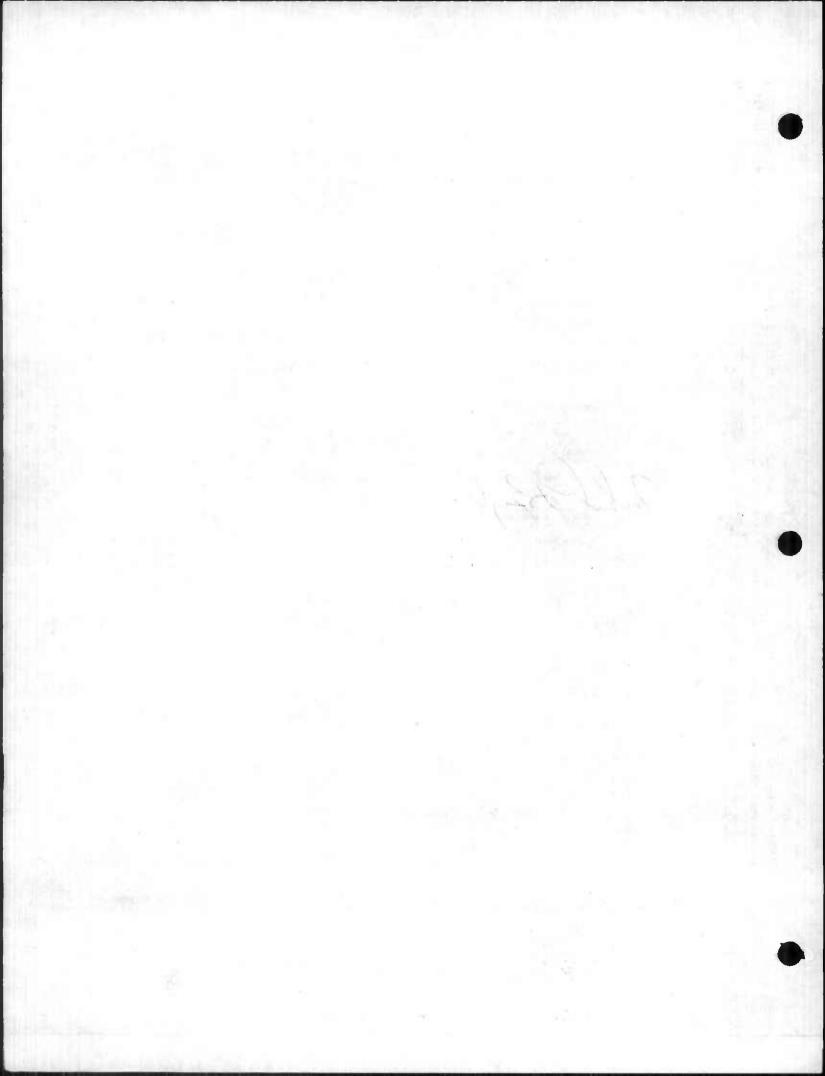
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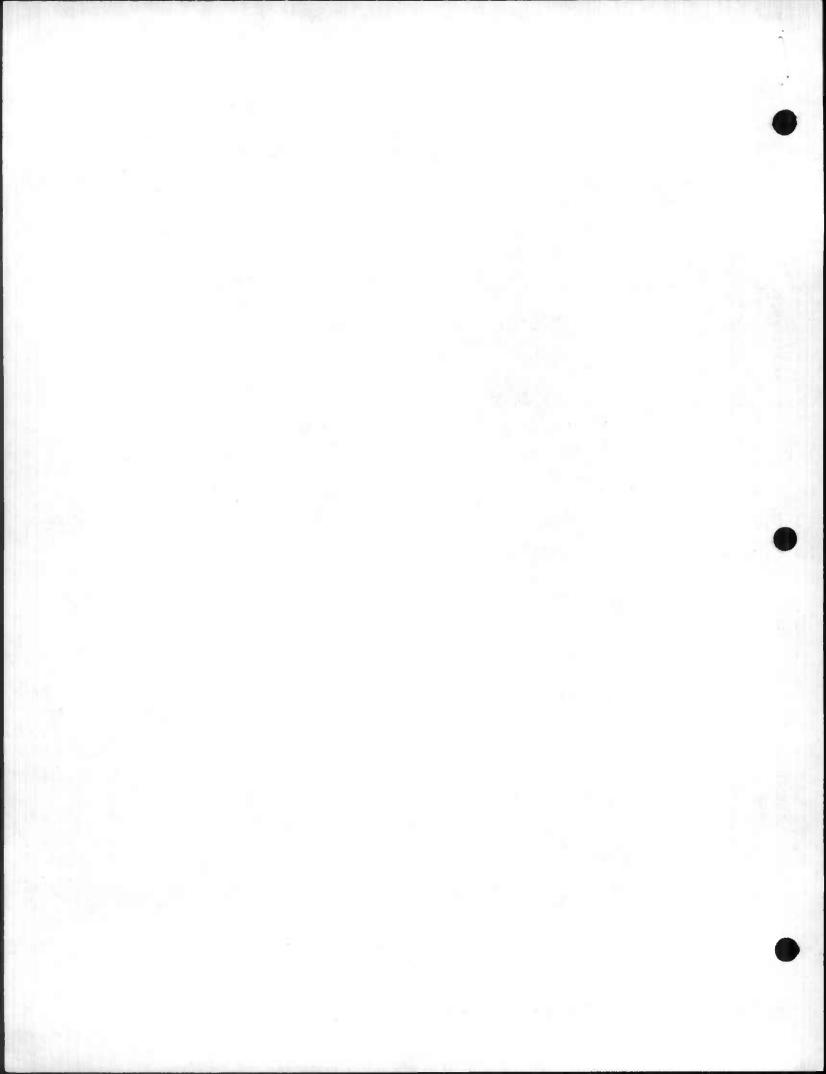
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Amended Item #16b, Per F.D., 11/09/2000, Carroll County, cew Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death NUTWELL Day HELEN Year **Physician** 5:35PM NOVEMBER,7,00 /Medical 4e Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN, BALTINOR If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) If Under 1 Yaar 6. Sax Birthplaca (Stata or Foraign Country) **Funeral** 1□M 20 F 329-09-9277 Director Ine 28, 1916 Illinois Usual Rasidence of Decedant the Marylend 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or flama 23a or 28a-f ahow the Medical Examinar must be notified at 1 Nas 2 No Funeral Director MD Carroll Eldersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5860 Springmount Court U.S.A.
14. Race - American Indian, 21784 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Wes Decedant Evar in U,S. Armed Forcas? Bleck, White, atc. Peges 1 and 2 should be filed within 72 hours after neat of Heelih and Mertel Hygiene. Interface other than "natural", or Neatury or other traumate event, the Medical Commission of the Medical Commiss 1 ☐ Yas 2 ☐XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ☐Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry National Geographic Elementary/Secondary (0-12) College (1-4or 5+) 9 Society Section Chief 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Frank A. Leven Jessalyn McHargue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Joseph W. Nutwell/son 5860 Springmount Ct. Eldersburg, MD 21784 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 □ Cremation 3 □ Ramoval from Stata permit. Pege Department of Important: If any Injury or oddee. Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 11/10/00 Brentwood, MD 22. Nama and Address of Facility Jeffrey N. Zunbrun Funeral Home 21. Signature of Eunaral Sarvice Licensee 6028 Sykesville Road Eldersburg, Maryland 21784 x emmones 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical PNEUMIONIA Examiner Physician/Medical Examiner physicien and the burial-transit Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760, Due to (or es e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 No 3 Unknown DEMENTIA Records, þ 24b. Wara autopsy findings available prior to Be Completed 24a. Wes en autopsy performed? complation of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica director, 25. Was casa rafarred to madical 26. Placa of Death (Check only ona) Hospital: 1 ⊠Anpatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 4 Homlcida 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signetura end titla of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 043462 1C-S. RAO. T.O NOVETOEN,7,00 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) NORTHWEST HOSPITAL CENTER NANDALLSTOWN, NO 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State MOUN 0 9 2000 Registrar **DHMH 16 Ray 6/95** 

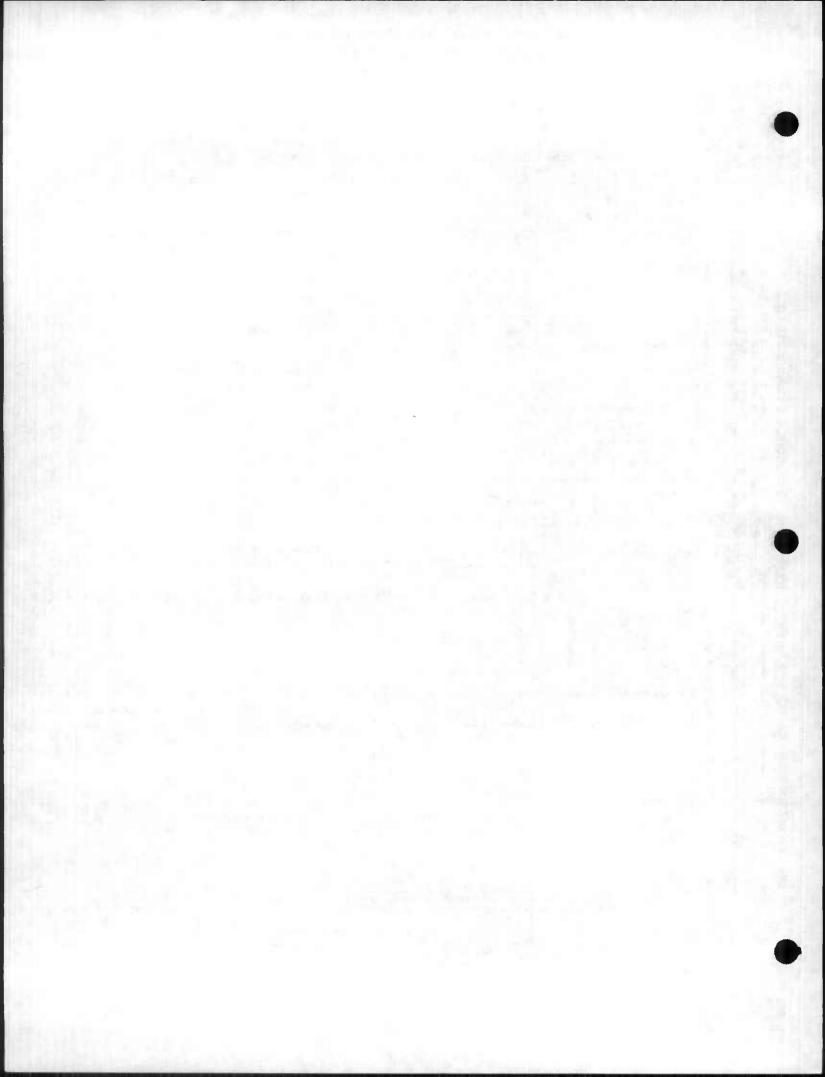


State	of Marylar	nd / Depa	rtment of	Health a	and Mental	Hy
		0	difficulty of	(Donall		

		Certificate of Death	Reg. No.	
	1. Decedent's Nama (First, Middla, Last)		2. Data of Deeth Month Dey Y	3. Tima of Death
Physician /Medical	WAYNE JACKSON PARKS, JR.		Nov. 5, 2000	" 4 AM
Examiner	4a Facility Neme (If not Institution, give street and number)	4b. City, Town, or Lo	cation of Death 4c. County of	Death
	27264 Greenwood Road	Denton	Carol	line
uneral	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Months Dave House Min	8. Date of Birth (Month, Dey, Year)	Birthplece (State or Forei Country)
rector	217-42-5314 ¹ ∇M ^{2□F} 56		Oct.12,1944	Virginia
	Usual Residence of Decedent	on the continu		Land hadde O'rest had
of at	MD Caroline	Denton		10d. Inside City Limi
be notifie Directo				
Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Who	
5 2	27264 Greenwood Road	21629	United	States
Pur	11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spett Yas, specify Cuban, Mexican, Puerto	Rican, etc.) 14. Rece -	American Indien, White, etc.
by F	1 ☐ Nevar Merried 2 ⚠ Married 1 ☐ Yes, 3 ☒ ᡬ No If Yes, Give Yaar or Datas:	1 ☐ Yes 2 ☒ No Specify:	Specify:	White
pet		Decedent's Usual Occupation	16b. Kind of Busin	ness/Industry
Completed	(Specify only highest grade completed)  Elementery/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working tife. DO NOT use retired)		
5	11	oultry Grower	Poult	try
Be	17. Fether's Neme (First, Middle, Last)		(First, Middle, Maiden Surnama)	
0	Wayne Jackson Parks, Sr.	Ethel	Grimes	
		b. Meiling Address (Street end Number or Rure		
	Sharon Parks/Spouse 2	27264 Greenwood Rd	., Denton, MI	21629
	comete	of Disposition (Neme of ary, cremetory or other place)	Date 20c. Location - Ci	•
	1 M Burial 2 I ICramation 3 I IBemoval from State	ord Cemetery 1	1/9 Federal	Isburg, MD
4	21. Signatura of Funeral Service Licensea	22. Name end Address of Facility		
ä	In Died 1 Gloma	22. Name end Address of Facility Framptom-Hawkins	-Eskow Funera	al Home, Pr
	23a. Part1. Enter tha disease, or complications that caused the death. Do	PO Box 43, Feder		2 1 6 3 2 Approximete
Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	consequence of):  CARDIO VASCULAR  consequence of):	DISEASE O	CHRONIC
page 2 should be detached for use. Completed by Physician/N	d		One Old Ashessa uses a set	
ys	Pert II. Other significant conditions contributing to death but not resulting	in the underlying causa given in Part I.	23b. Did tobecco uss contr	Probably 4 Unkno
×	Chronic ObsTRUCTIVE LU	ING DISERSE	10100 20100 9	TOURS Y
b p				24b. Were autopsy finding
eted			performed?	available prior to completion of cause of death?
To Be Comple				
ပိ			1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
Be	25. Wes case referred to medical examiner? Hospitel:	Other	h (Check only one)	
. To	1 Inpatient 2 ER/O	utpatient 3 DOA 4 Nursing Ho	me 5 Residence 6 □Other 28d. Describe how injury occurred	
lon	1 Neturel 5 Pending (Month, Dey Year)	Time of lnjury at Work?  M 1 □ Yes 2 □ No	Edd. Describe now injury occurred	
Certification:	2 Accident investigation 3 Suicide 6 Could not be 289 Place of Injury At home for		28f. Location (Street and Number	or Rural Route Number
T T	determined  determined  28e. Place of Injury - At home, fibuilding, etc. (Specify)	erm, street, ractory, onice	City or Town, State)	or rigrer rioute resilion,
edical Co	29a. Certifier  (Check only  Medicat Examiner: On the basis of examination of			
	one) end menner steted.			
Σ	29b. Signature and title of certifier	M = 29c. License number	29d. Date signed (	(Month, Dey, Year)
	C Hensen III reputy 1	111IN 21460T	6 NOV 0	1000
	30 Name and eddress of person who completed cause of death (Item 23a)	(Type)Print)Par 1007.	215 11 112	2.405
	UNRISIEN E- JEWEN MID.	YIU. POX 690, DE	:NION MID 2	1629
State	31. Dete filed (Month, Day, Year) 32. Registrar's Signature			

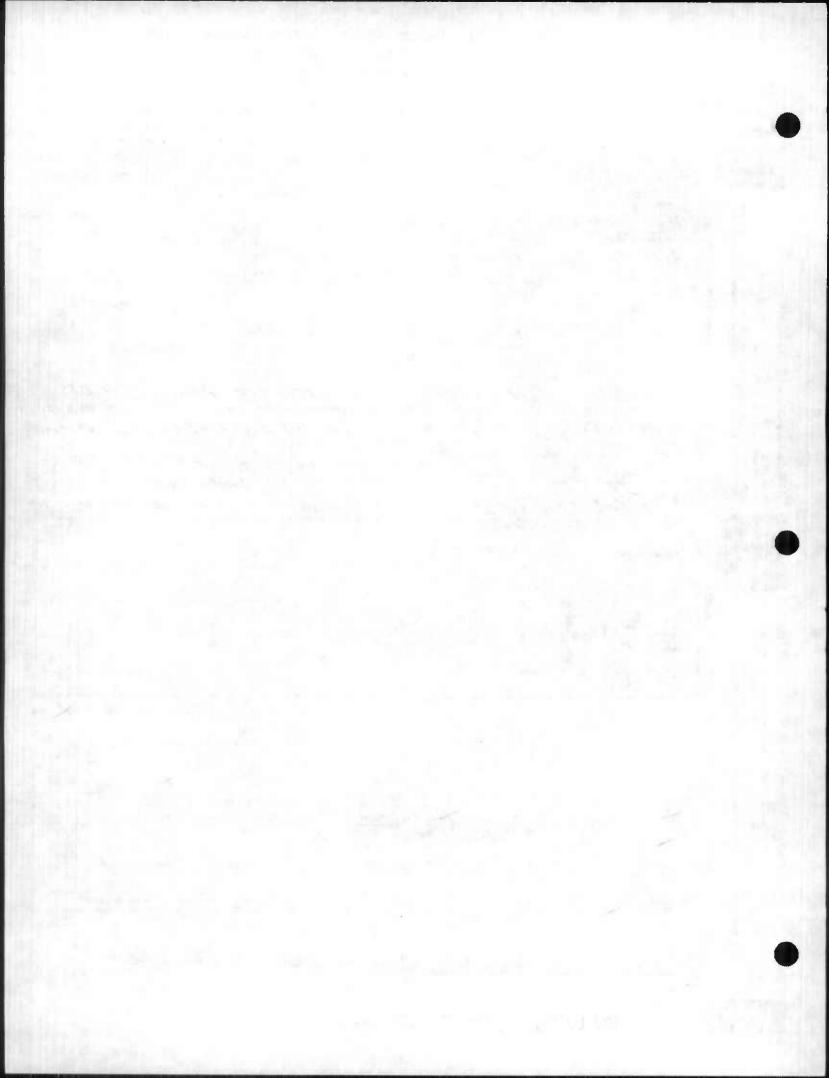
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State Registrar



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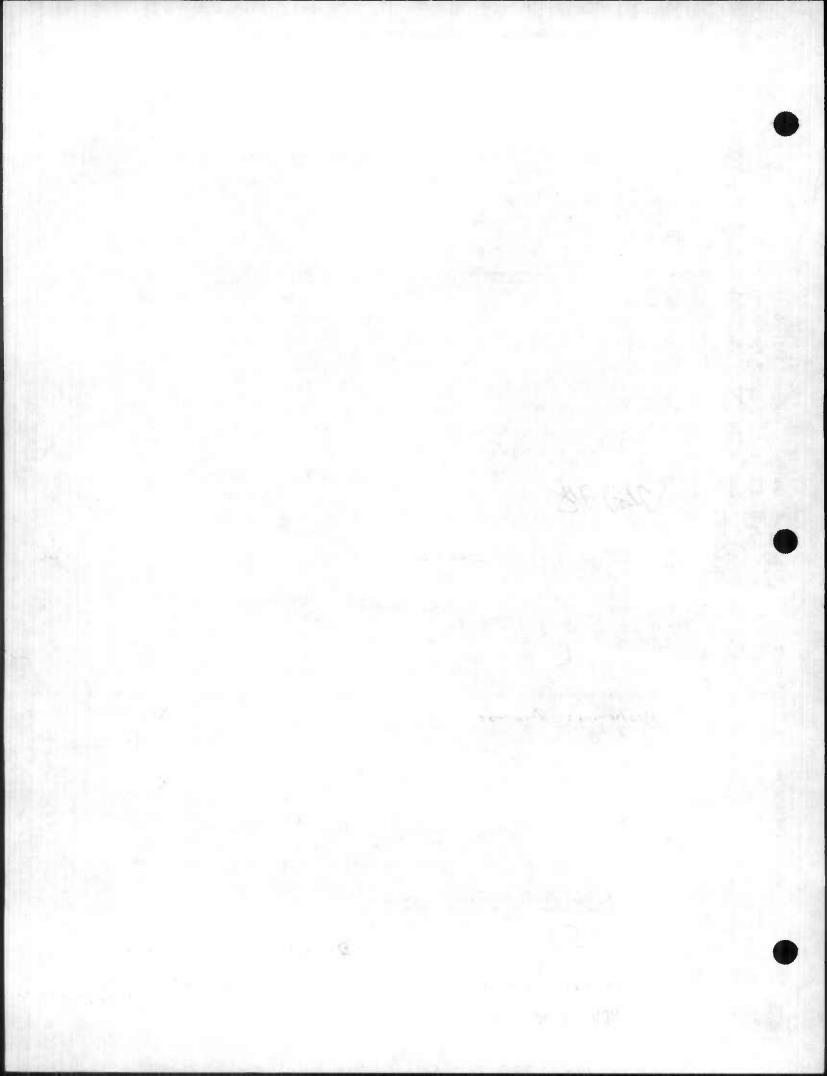
				Certificate of	Death	Reg. No.	0 / 7 2 0
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	ineral rector	284-12-8809	PM 2 F 7. Aga (In yrs.	last birthday) If Under 1 Year Months Deys	If Under 24 Hrs. 8 Hours Min.	Dete of Birth (Month, Dey, Year) ULY17, 1922	9. Birthplaca (Steta or Foreign Country)  MICH 16-44  S
2		Usual Rasidence of Decedent  10a. State 10b. County	10c Cit	y, Town or Location			10d. Inside City Limits
e Maryla	tor 28a-1 sho be notified at Director	MD. CARRO	4 1	WESTMIN STE	R		1 des 2□ No
6 46		10e. Street and Number AP	IN PARK DI	101. Zip Code 2//	57	10g. Citizen of W	
5-0020 72 hours after dea	Examiner must Examiner must I by Funeral	11. Merital Stetus  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Evar in U. Armed Forces? 1 ☑ Yes 2 ☐ No If Yas, Give Yaer or Detes:	S. 13. Wes Decedent of I If Yes, specify Cub	Hispanic Origin? (Specifican, Mexican, Puarto Rid Specify:	y Yes or No- can, etc.)  14. Rece Black  Specify.	- American Indian, k, White, etc.
2 20	alcal.	15. Decedent's E. (Specify only highest gre	ducation	16a. Decedent's Usuel Occup (Giva kind of work done	pation dunna most of working	16b. Kind of Bu	siness/Industry
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/lar	To B	ELISHA	POLKING HO	RNE	MINNI	E ANNE	WEBB
ary sho	-	19a. Informent's Neme/Reletionship (	Type, Print) / WIFE		t end Number or Rurel F	Route Number, City or Town,	State, Zip Code) AD, Z115
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Ba Fig.	A POR	I Toler A	Mera			HONE WES	to the same of the
	6	23a. Pert1. Enter the disaase, or com shock, or heart failure. List only	plications that caused the deat	h. Do not anter tha mode of dyi	ng, such as cardiac or r	espiretory arrest,	Approximete Intervel Between
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	dical miner	Immediate Cause (Final disease or condition	HSCVI				Years
E A GI	0	resulting in death)	Due to (c	r es e consequence of):			
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9	0 2	resulting in death) Lest	Due to (o	r es e consequanca of):			
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0 5	gned by the attending be detached for use a by Physician/M	Part II. Other eignineant conditions of	online and the second of the s	uning in the underlying cause gr	VOCA III POLLI.		3 □ Probably 4 Unknown
2	d by P						
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I Re	age 2					1 □ Yes 200 No	1 ☐ Yes 2 ☐ No
ta ::	rector, pag	25. Was case referred to medical			26. Place of Death (		7,7,1
		examiner?	Hospitel: 1 Inpatient 2	SR/Outpatient 3 DOA Ot	her:	5 ☐ Rasidence 6 ☐Othe	er (Specify)
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- A	State Registrar	31. Dete filed (Month, Day, Year)  NOV 13	32. Registrer's Signa	iture			



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State of Maryland / Department of Health and Mental Hygiene 00 37429

				Ce	rtificate d	of Death			Reg. No.			
		1. Decedent's Name (First, Middle, Last	)					2. Date of De	eth Day	Year	3. Time of Death	
	hysician /Medical	VII	RGINIA		PIC	KETT		NOV.	8, 200		4:25 PM	
	xaminer	4a Facility Name (If not institution, give GLADE VALLEY NU		HAB. C	TR.	4b. City, To		cation of Deat		y of Death DERI	CK	
	neral ector	213-18-8683	TM ONE	s. last birthday) 79 Yrs.	Months Da		24 Hrs. Min.	8. Dete of Bir (Month, Di 2 / 9 / 1	ny, Year)		place (State or Foreign ntry) YLAND	
pu ,		Usuel Residence of Decedent  10a. Sfete 10b. County	100.0	City, Town or Lo	ocation						10d. Inside City Limits	
in Maryta	be notified at Director	MD. CARROL			TMINST	ER					1X Yes 2 □ No	
D with th		10e. Street and Number 480 AVENEL CIR	CLE		10f. Zip Coo				10g. Citizen of USA	What Coul	ntry?	
	by F	11. Meritel Sfetua  1 Never Merried 2 Merried  3 Wildowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 Yes 2X No If Yes, Give Yeer or Detes:		Wes Decedent If Yes, specify ( 1 ☐ Yes 2 ☒	Cuban, Mexical	n, Puerto	ecify Yes or No Rican, etc.)	Ble	ce - Americ ck, Whita, WHIT		
2 2	fical fical	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usuel Oc kind of work do	cupation	t of work	ina	16b. Kind of B	usiness/in	dustry	
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Alenta Menta	To B	CLA	AYTON LEE STONER MARY					STA	ANSBURY	<u></u>		
Maryland d 2 should be file th and Mental Hy		19a. tnforment's Neme/Reletionship (T)	pe, Print)	19b. Meiii	ing Address (St	eet and Numb	er or Run	al Route Numb	per, City or Town	, Stete, Zij	p Code)	
- To m !	ar tra	DONNA E. ALBAN	- DAUGHTER	403 1	MAIN S	r., NE	EW W	INDSOL	R, MD.	217	76	
Baltimore,	or offi	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ F	Removei from Stete	cemetery, cre	osition (Neme of matory or other	plece)		Dete	20c. Location			
III P.	injury injury	4 ☐ Donation 5 ☐ Other (Specify)  21. Signefure of Funerel Service Licens			ES CEMI				0 NEW			
n ad	A Sun	12kg) 78								YUNERAL HOME ISTER, MD.21157		
		23a. Pert1. Enter the diseese, or composhock, or heert feilure. List only o	icetions thet ceused the de- ne cause on each line.	eth. Do not en	ter the mode of	dying, such as	cardiec	or respiretory e	errest,		Approximate interval Between Onset and Death	
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D, executed	in end ial-transit Examiner	Sequentially fist conditions, if any, feeding to immediate cause. Enter Underlying	bDue to (or es a consequence of):									
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raquir	should should							24a. Wes	s en eutopsy ormed?	C:	Vere eutopsy findings veileble prior to ompletion of cause f death?	
The la	page 2							10	Yes 200No	1	☐ Yes 2☐ No	
mu:	certificate rector, pag	25. Was case referred to medicel				26. Plec	e of Deet	h (Check only	, ,	1		
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Jing Ph	£	27. Menner of Deeth  1 Naturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury		Injury at Work?	No	28d. Describe	how injury occu	rred		
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H SI	- 0	D43091						TOLL HOUSE AVE MEDERICAL				
		30. Nema and address of person who or	ompleted cause of deeth (Ite	em 23e) (Type	, Print)	801	7	OLL	House	EA	21701 mD	
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В	Registrar	NOV 132	ann Sener	a 1	9 /2	2.11						

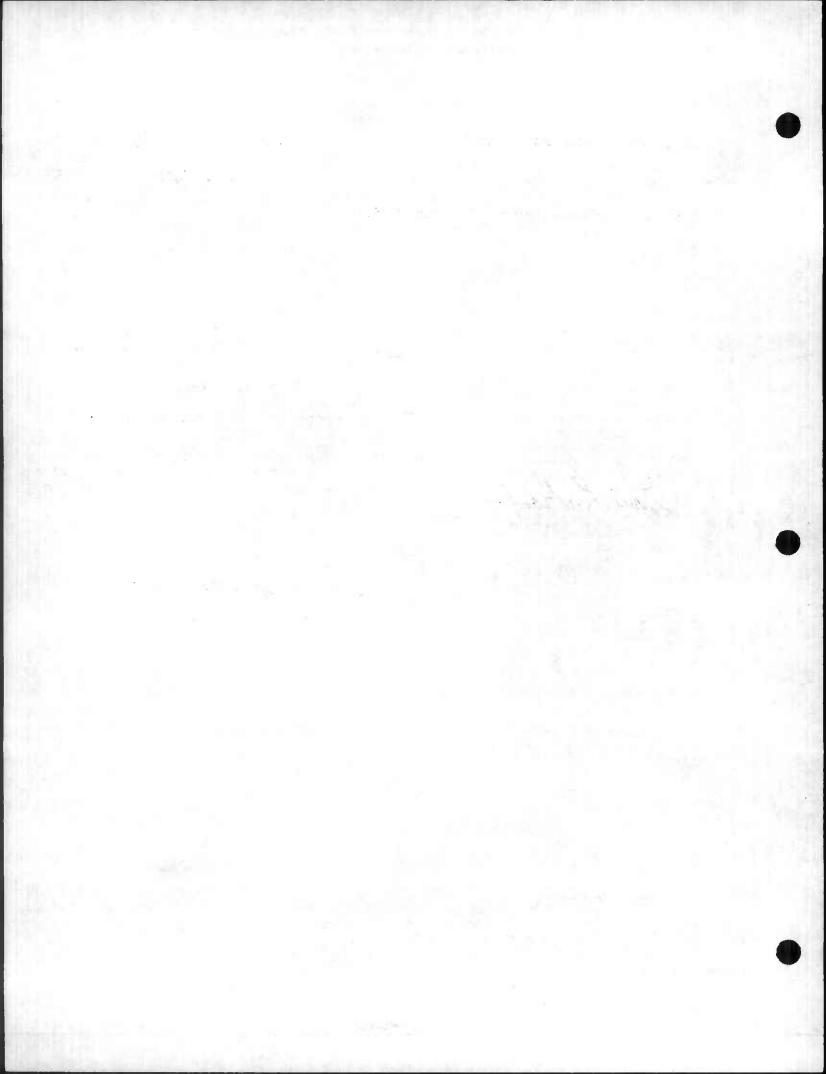


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	Physicia		Decedent's Name								2. Data of D	Day	y Yas		3. Time of Death
	/Medica	al	Earl Facility Nama (If		ncis		berts			4b. City, Town, or	November			- 045	7:11 AM
2	Examine	er **								Clinton	Location of Dea		County of De		rge's
4-	F	5.	Social Security No		and nosp 6. Sex		n yrs. lest birti	hdev) 1	f Undar 1 Yaar		8. Date of Bi				ce (Stete or Foreign
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	h wit		2810 Ka	rnal A	zenue				20748			Ur	nited S	Stat	ces
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2	filed within Hygiene. other then sent, the We	De Completed	12	First Adiddle I		A	B	aker		10. Moth aria Na	me (First, Middle		Giant 1	1000	ıs
anc		0 0	V. Father's Neme (A		ast)					Margar		KNOWI			
Z	2 should be and Mental is marked of surnatic evi		9a. Intermant's Na		ip (Type, Print)		19b.	Mailing /	Address (Stree	t and Number or R				a, Zip C	code)
Baltimore, Maryland	s 1 and 2 should f Health end Mer tem 27 is marke other traumatic		Joyce Ann	n Rober	ts (DAUC					ort Way,	Dagsbor	o, De	elware	199	939
ore	of He	20	a. Method of Disp		3 □Removal from	m State		y, cremet	ory or other ple		Date		ocation - City		
Ë	Pag ment ant: I uny o		4 ☐ Donation			ii Otato	Cedar			ery Nov 6			tland,		
Ball	permit. Pages 1 and 2 Department of Health e Important: if Item 27 is any Injury or other tra pnce.	2	1. Signatupo of Fur	nerai Service L	1/1			22. N Ale	ame and Address	ess of FacilityLes Ferry F	Road, Cl	into	me,Inc n, Mar	ylar	nd 20735
		2	3a. Part1. Enter the	disease, or o	complications tha	t caused the	death. Do n	ot enter t	he mode of dy	ing, such as cardia	c or respiratory	arrast,		i A	Approximata nterval Between
	Physician		3113311, 31 11331	t tandro. Erot o	// //	7 1		d		3				C	Onset and Death
	/Medical Examiner	di	nmediate Cause (F isaasa or condition isulting In death)	Final	a. At	phi	CY	un	KER	_			32.0	i	
ı.	D #				Ri	C. Due	e to (or as a c	onseque	nce ot)	he 1	neu	M	Ance	1	
,	icate be executed physician and the burial-transit	dical Examiner	equantially list con any, leading to im- ause. Enter Under ause (Disease or i at initiated events	ditions, mediate	Q.	Due	to (of as a c	onseque	nce ot):	mon s	her!	on	10 11		
\$8760,	ysicia na bur	E Ch	ause (Disease or i	njury	c. C	Due	to (or as a c	onsequer	nce of):	118004	7-01		7		
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Box	attending for use e	2			de	~	11/11	rai	man	200	11000	porc	Leca	1 6	1
. E	the att	PE	art II. Other signific	cant condition	e contributing to	death but n	ot resulting in	the unde	orlying cause gi	iven in Part I.	23b. Dic	tobacco	use contrib	uts to t	he causs of death?
, P.O.	es that the deeth cerigned by the attendin	y Pany			- 1						10	Yes 2	2□ No 3□	Proba	Unknown
Division of Vital Records,	Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use e	Pe Completed by Physiciany									24a. Wa	s an auto	psy 24	avail	e autopsy tindings lable prior to pletion of cause
Rec	ysician: The law s certificate has b director, page 2 si	- John Compiler			4 1 1 2						10	Yas 2	MNo	ot de	esth? Yes 2□ No
ta	certificata rector, pag	D 25	5. Was case reterm	ed to medical					4.0	26. Place of De	eth (Check only		700		
>	s cert	0	axaminer?	No	Hospitel:	Inpatient	2□ ER/Out	patient	3 DOA O	her:	Home 5 Res		6 Other (S	pecify)	
0	Ph pral		. Menner of Death		28a. Dat	e of Injury onth, Dey Ye	28b. T	Ime of	28c. Inju	iny at	28d. Describe	how inju	ry occurred		
io	Attending ir death. ector: Atter by the tune	atio	1 Accident	5 Pending investige	ation	, , , , , , , , , , , , , , , , , , ,		ijury		Yes 2□No					
Divis	at or Atta	27	3 Suicide 4 Homicide	6 Could no determin	of be ned 28e. Pla buil	ce of Injury Iding, etc. (5	- At home, far Specify)	m, street	, tactory, office		28f. Location City or To	(Street er own, Stete	nd Number or e)	Rurali	Routa Number,
	<b>2</b> 8 2 2 ± ·		9a. Cartifier (Check only	Certifying Medical E	xaminer: On the	ne best of m basis of exa	amination and	death od	ccurred at the titigation, in my	ime, date and plac opinion, deeth occ	e, and dua to the urred at the time	e cause(s e, date and	) snd manna d place, snd	r as stai	ted. the cause(s)
	To the Hose For		b. Signature and	itte of certain		1	1.1		29c. Licen	se number		29d. Da	ate signed (M	onth, Di	ay, Year)
	7/12	)	Va	ag.	R	10	1.1		DIL	1827		No	V 3.	2	000
	(10)	30	Name and addre	Dac		use of death	(fem 23a) (		025	Rocki	ille 1	nd	200	151	7)
	State	31	I. Date filed (Mont)		7	Registrar's	Signatura	~ 11		~ 000	1112	100	000		
	Registra		MAAA	2000	Denews	1	9. 1	20.	1.1						

Earl

Roberts,



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ] Certificate of Death 1. Decedant's Neme (First, Middla, Last) 2. Date of Death 3. Tima ot Death Dev **Physician** ARMENTIA LORETTA ROUNDTREE 405 04-2000 /Medical 4e Facility Nema (# not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Southern Maryland Hospital Prince Georges' If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yeer 6. Sex 7. Age (In yrs. last birthdey) Birthplace (Stata or Foreign Country) **Funeral** 1 M 200 Months Days 48 Yrs. 244-92-5948 Director June 18, 1952 Wash. Usual Rasidance of Decedant the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. tnsida City Limits 28a-f show rail, or items 23s or 28s-f show 1⊠Yas 2□No Directo Maryland Prince Georges Camp_Springs, 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5109 Sharon Road 20748 USA Funeral 72 hours after death 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien 11. Marital Status Black, Whita, atc 1 ☐ Nevar Married 2 ☑ Married Specify: Black 1 ☐ Yas 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Al Hygiene.

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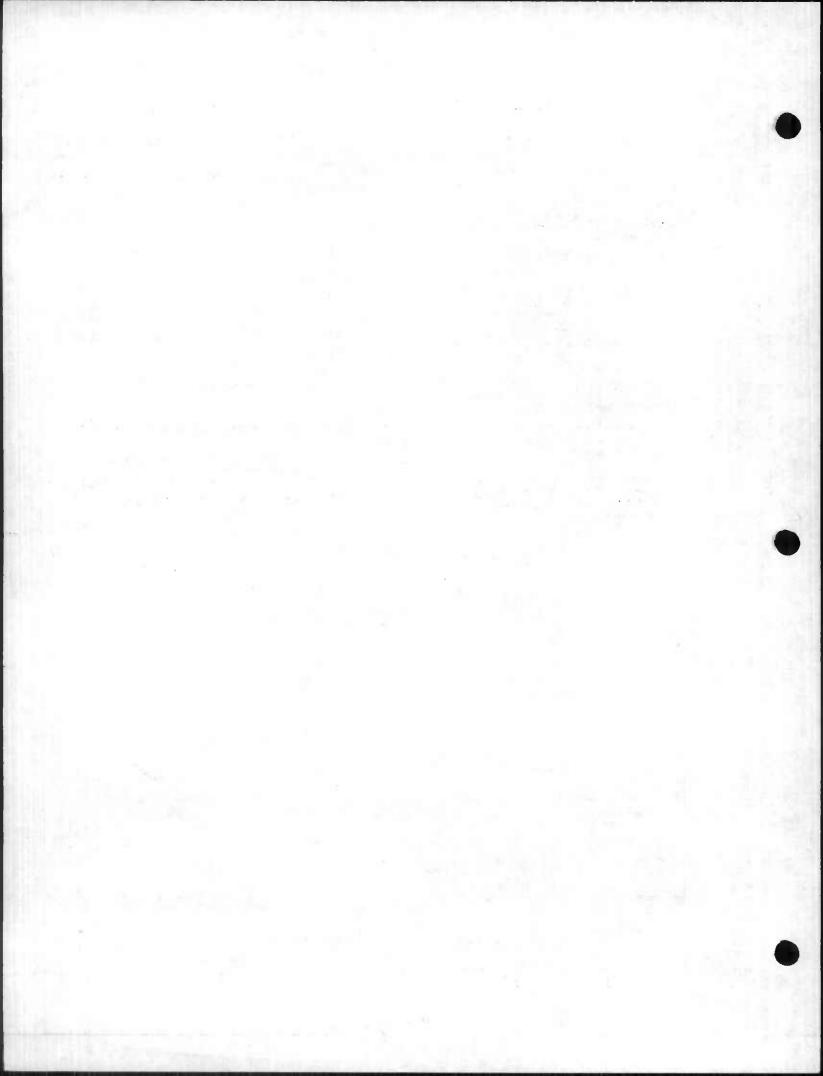
of me Wedical E "netural" Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Geico Insurance Co. Elementary/Secondery (0-12) College (1-4or 5+) Underwriter 18. Mother's Name (First, Middle, Maiden Surnama) 17. Fathar's Nema (First, Middla, Last) Be 2 should be and Mentel marked Elisha Gay Alice Daniels permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other treum once. 19e. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Alton G. Roundtree 5109 Sharon Road, Camp Springs, MD 20b. Place of Disposition (Nama of cemetary, crematory or other place) Dete 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Maple Grove Church Cem. 11-11-00 Chocowinity, NC 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Lices 22. Nama and Addrass of Facility Strickland Funeral Svcs., P.A. 6500 Allentown Road, Camp Springs, MD 23a. Partf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** Candiac Immediata Causa (Final diseesa or condition resulting In death) /Medical Examiner Physician/Medical Examiner as the burial-transit certificate be swecuted Sequentially list conditions, if any, teading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants and the attending physician Dua to (or es a consequance of) rasulting in daath) Last USB Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? page 2 should be detached been signed by 1 Yes 2 No 3 Probably 4 Unknown p 24a. Was an autopsy performed? 24b. Wara sutopsy findings available prior to Completed completion of cause of death? this certificate has 2 PNo 1 ☐ Yas 2 ☐ No 1 Yas director. Be 25. Wes casa referred to medicel axaminar? 26. Place of Daath (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Medicai Certification: To 11 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Naturat 5 Pending 1 ☐ Yas 2 ☐ No invastigation Director: / 2 Accidant 28t. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicida 6 Could not be detarmined 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by or A after 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. 29a. Certifier 29b. Signature and title of certifie 29c. Licansa number 29d. Date signed (Month, Day, Year) d cause of death (Item 23a) (Type, Pgint) Dr. Clinton. Day, Year) 31. Date tiled (Month. 32. Registrar's Signatura State NOV 0 2000

**ORIGINAL** 

Registrar

**DHMH 16 Rev 6/95** 

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**Funeral** 

Director

t than "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at

d 2 should be filed within 7; th and Mentel Hyglens. 7 Is marked other than "no

**Physician** 

/Medical

Examiner

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The law requires that the death certificate be executed

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To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fun

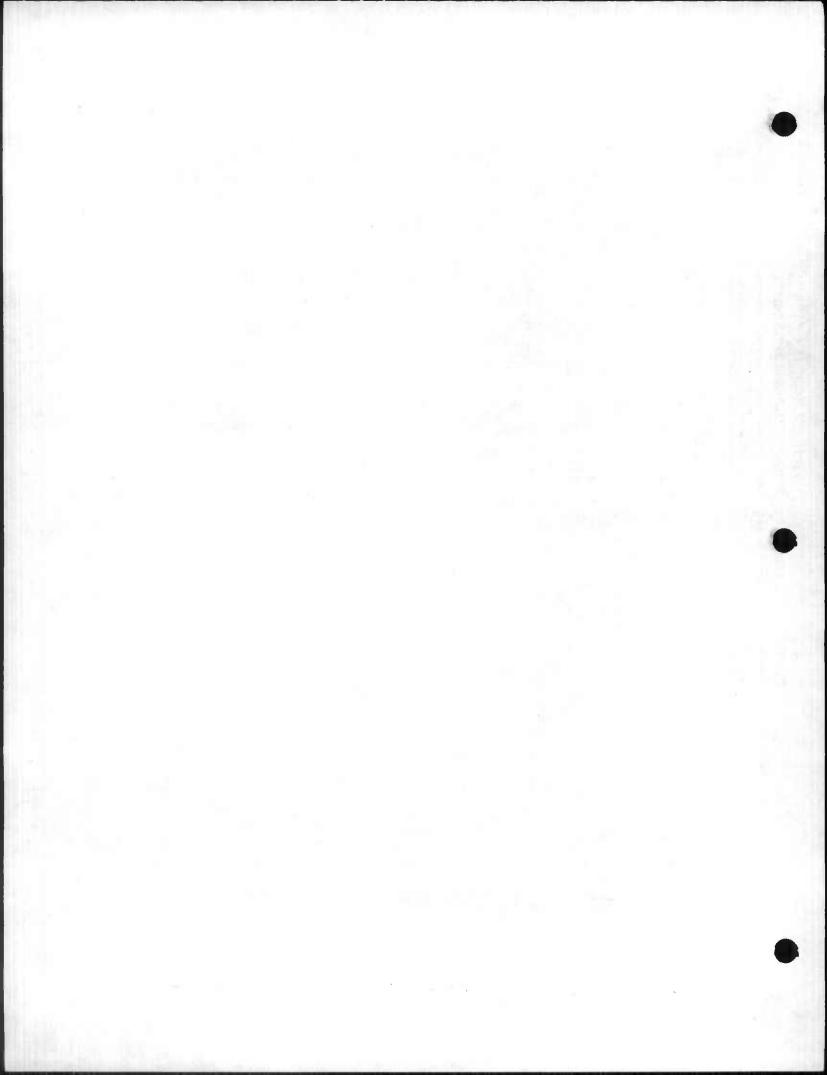
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Lucele Rebecca REYNOLDS November 12, 2000 4:06 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Reeders Memorial Home Boonsboro If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 70 April 9 1930 West Virginia 234-68-4892 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits 1 X Yes 2 □ No Director Maryland Washington Hagerstown 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 Potomac Towers 21740 U.S.A. 12, Wes Decedent Ever in U,S. Armed Forces? 1 | Yes 2 D No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: P 3 ☐(Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Domestic Cook Cook 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William Edward Stone Florence nmn Wise 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven A. Stone - Son 3022 Shawnee Drive Winchester, Virginia 22601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Greenlawn Memorial Park 11/16/00 Williamsport, Md. 22. Name and Address of Fecility Minnich Funeral Home 21. Signature of Funerel Service Licensee 415 E. Wilson Blvd. Hagerstown, Md. 21740 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert tailure. List only one cause on each line. Approximete Intervel Betw Onset end Death Immediate Cause (Finel disease or condition resulting in deeth) 3-Pristy melliter Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown antre Almophy ortropassis þ 24b. Were eutopsy tindings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) To 1 | Yes 2 | 1√0 Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Andrsing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Haturel 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edical 1 C-Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartifier - ( DUTINO) D18019 NOV 13,2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Dr. Vasant Datta 334 Mill Street, Hagerstown, Maryland 21740/301-739-7100 31. Dete tiled (Month, Day, Year) NOV 1 4 2000 32. Begistrar's Signature State

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month PAULINE MAE REINERT 11/ 11 2000 04:25 hrs 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Hartley Hall Nursing Home Pocomoke City Worcester If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1□ M 20 F Yrs 181-30-6364 11/28/1907 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1006 Market Street 21851 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□Yes 20 No 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis O. Bechtel Lizzie Rheuma Kern 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Althea Billig/ Daughter 3215 Stockton Rd. Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 11/12/08alisbury, MD 21. Signeture of Fungui Service Licensee 22. Name and Address of Facility M6/129 103 Linden Av Holloway Melson F.H., P.A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Pocomoke MD Interval Between Onset end Deeth Dimentia, Vascular Type Immediate Cause (Final diseese or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contributs to the cause of death? 1 Tes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 28 No 25. Was case referred to mega examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Director

Funeral

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Completed

MD

traumetic event, the Medical Examiner must be notified at

mportant. If item 27 is merked other than "natural", or items 23a

Hygiene.

and Mental

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Whine Reinert

end I-transit ettending physician efor use as the buriel been signed by the should be detech To the Hospital or Attending Physician: I within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Box 68760,

P.O. I

Records,

Division of Vital

Examine Physician/Medical Completed by 80 Certification: To

Medical

27. Manner of Death 1 KNatural 2 Accident 3 Suicide

29a. Certifier

4 - Homicide

29b. Signeture and fitle of certifier

1 Yes 25 No

5 Pending Investigation 6 Could not be determined

28a. Date of injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how Injury occurred

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) end manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, end due to the ceuse(s) end manner stated.

29d. Date signed (Month, Day, Year)

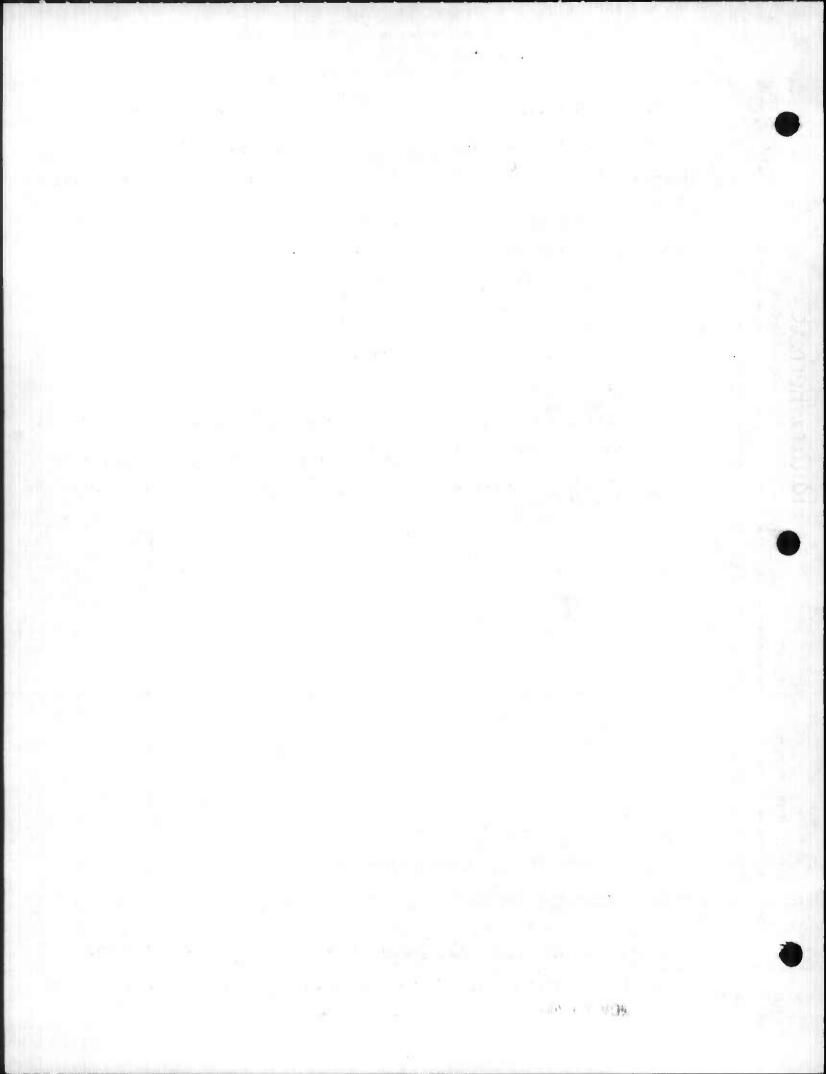
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, M.D. 21801

3EJ DOA

State Registrar

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician** 1330 Mary Virginia Schmidt 12000 11 /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Prince Georges Hospital Center Cheverly Prince Georges 7. Age (In yrs. lest birthday) If Under Months | If Under 1 Year | If Under 24 Hrs. | S. Dete of Birth | S. Dete of Birth | Property | Sept. 25,1917 | Wash. 5. Social Security Number 6 Sex Birthplace (Steta or Foreign Country) **Funeral** 1□M 2☑F Yrs. 578-24-3971 Director 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow ral', or items 23a or 28a-f abov Examiner must be notified at 1 ☐ Yes 2 No Director Md. Prince Georges Upper Marlboro 10a. Street and Number 10g. Citizen of What Country? 1077 Largo Road Apt. 610 20774 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2√ No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within 7 Department of Health end Mental hygiene. Important: If item 27 la marked other than "r any Injury or other traumatic avent, the Med Elementery/Secondary (0-12) College (1-4or 5+) Store manager Retail 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Cloey E. O'Neal John E. Holladay 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 20720 19e. Informant's Name/Reletionship (Type, Print) Joyce Donaldson daughter 12726 Hillmeade Station Rd., Bowie, Md. 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Lakemont Mem. Gardens11-07-00 Davidsonville, Md 22. Name end Address of Facility 21. Signeture of Funeral Service Licensee Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical , LIRINARY TRACT INFECTION Examiner Due to (or es e consequenca of): Examiner VASCULAR 1-21 P(-21171 Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760, ISCHEMIC COLITIS Physician/Medical Due to (or es e consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yas 2 No Division of Vital Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifica 25. Was cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Mennay of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Maturel 1 Yes 2 No 2 Accident 6 Could not be detarmined 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) 2 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one)

Registrar

29b. Signeture and title of cartifier

31. Dete filed (Month, Day, Year)

SION

NOV 0 6 2000

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

BERHANE

3f. Registrer's Signature

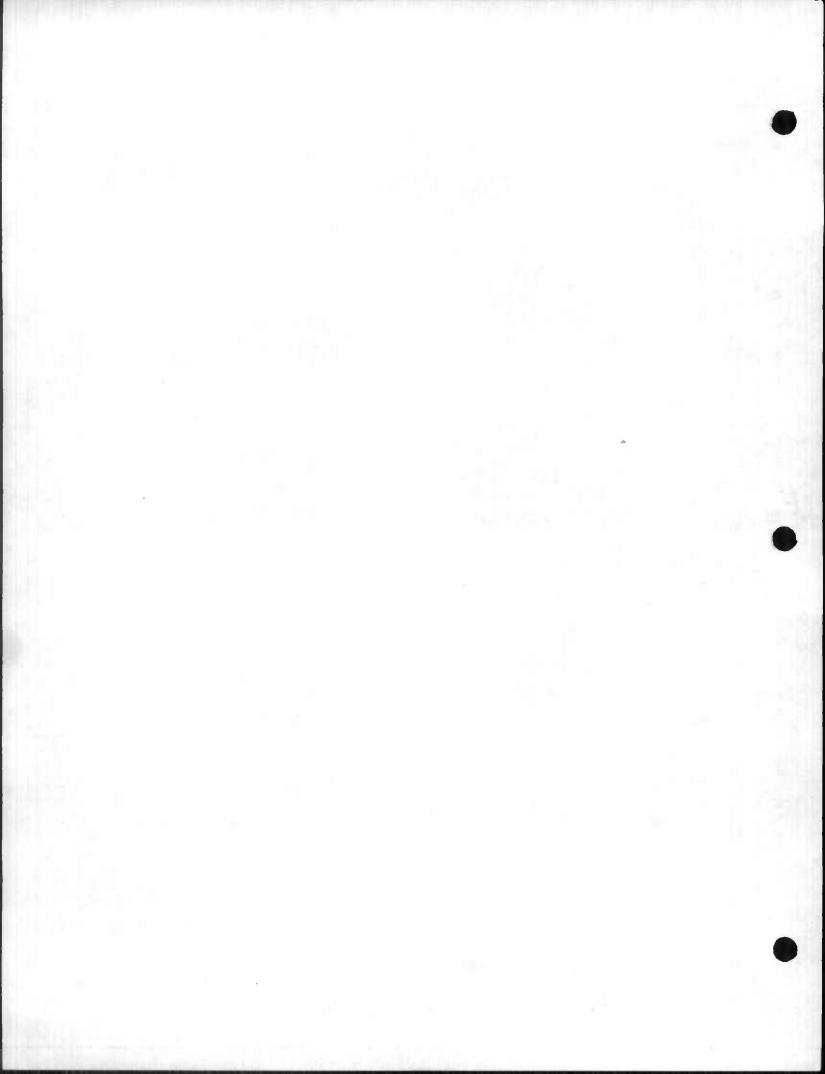
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29c. Licanse number

HOSPITAL DRIVE

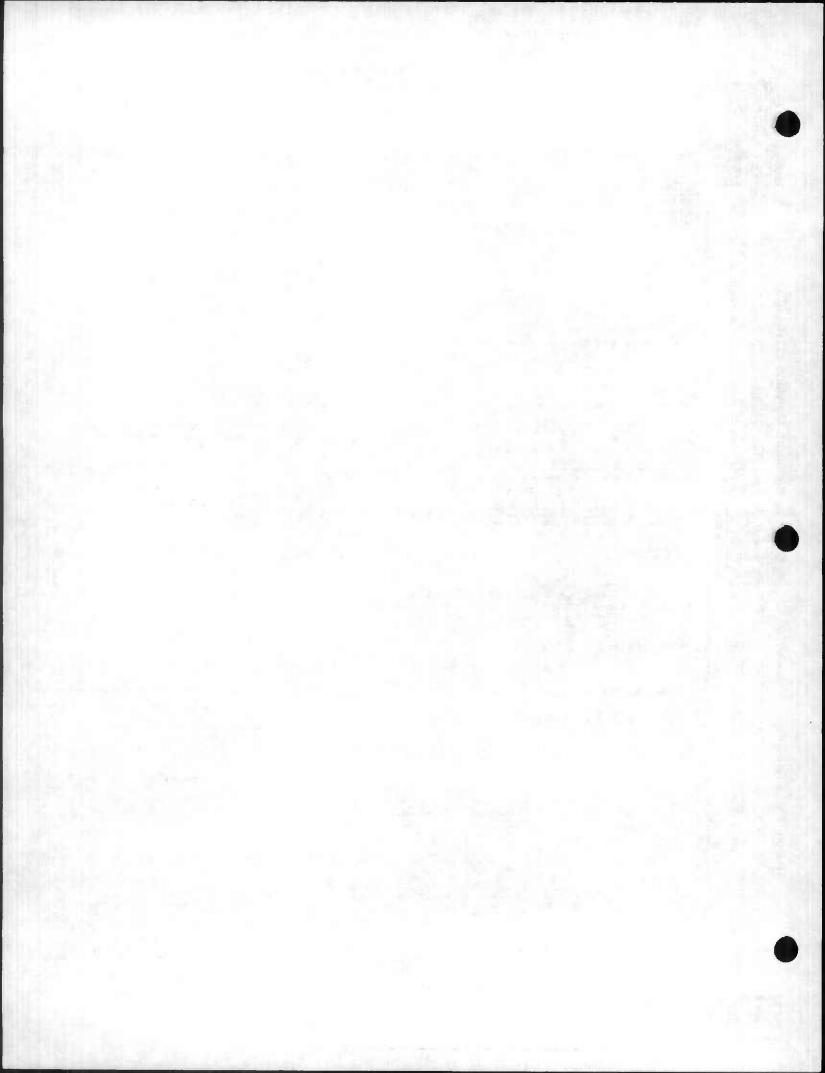
29d. Date signed (Month, Day, Year)

CHEVERLY, MD 20784



# Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3 7 4 3 5

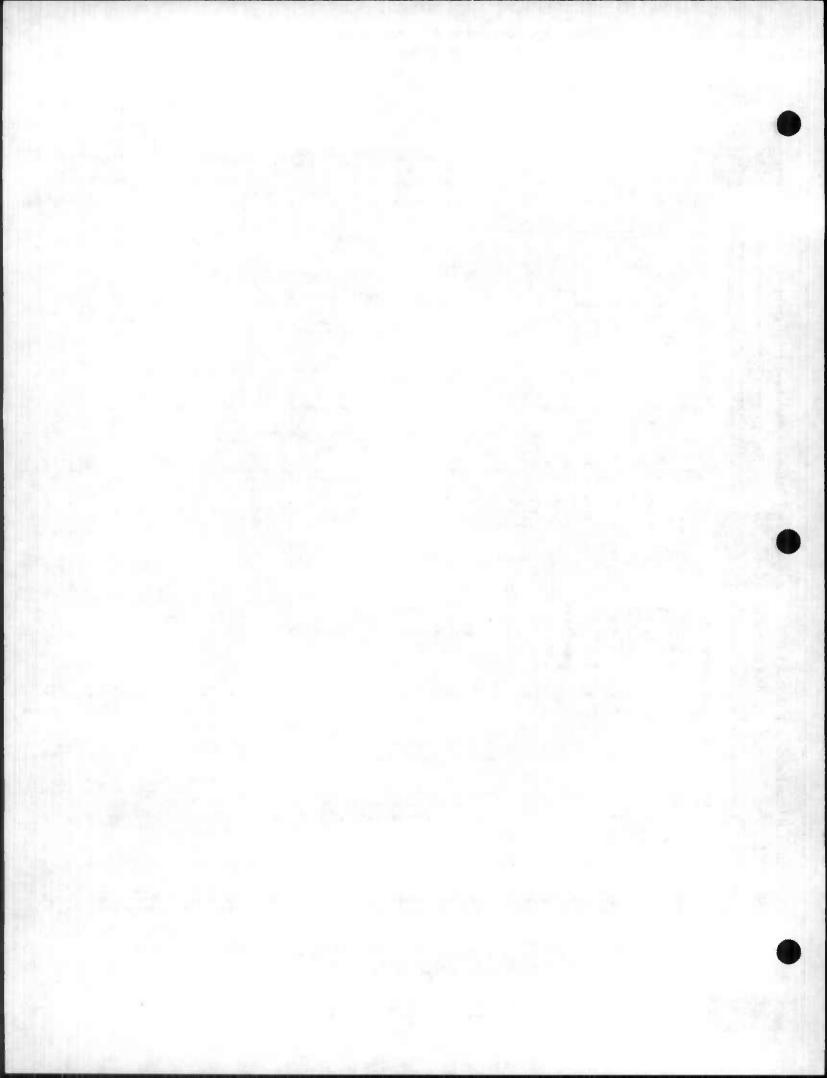
ician	1. Decedant's Nama (First, Middla, Last)							2. Data of Dea			3. Tima of Death	
	JOSEPH (NMN) SECONDARI							Month NOVEMBE	ER 8 20	Year OO	4:30 PM	
cal ner	4a Facility Nama (If					4t	. City, Town, or L	1-1-	-		4.50 111	
iei			HOSPITA			1	HAGERSTO	STOWN WASHING		CTON		
al	5. Social Security No	umbar 6. S	ax 7./	Aga (In yrs. las	or outrody)	thday) If Under 1 Yaar   If Undar 24 Hrs.   8. Date					lece (Stata or Foreign try)	
Д	101-32-5 Usual Residence of	338	XIM 2□F	76	Yrs. Month	s Days	Hours Min.	MAY 24,	1924	Coun	ÏTALY	
	10a. Stata	10b. County		10c. City,	Town or Location		CHAIR T	10d. fnsida City Li				
tor	MARYLAND	WASH	INGTON				BOONS	BORO			1 ☐ Yas 2 No	
Directo	10e. Street and Num				10f. 2	Cip Coda	200110		10g. Citizen of What Country?			
1230 Int.	518 NORT	H MAIN ST	CREET			21	713		U.	S.A.		
	11. Marital Status		12. Was Deceder Armed Forces		13. Was Dad	edant of Hispanic Origin? (Specify Yas or No ecify Cuban, Maxican, Puarto Rican, atc.)			14. Rac	an Indian,		
	1 Nevar Marrie		1 Yas 2 If Yas, Giva	No		2∰ No		, riioari, are.,	Specify		HITE	
per		15. Decedant's Ed				Jsual Occupation			16b. Kind of Businass/Ir			
ple		(Specify only highast grada complated)  Elemantary/Secondary (0-12) Collega (1-4or 5+)			(Giva kind of the lifa. DO NOT	vork done di use retired)	uring most of work	ring				
TO.	5+			3.7	M	EDICA	L DOCTOR	R PRIVATE PRAC			RACTICE	
Be Completed	17. Falhar's Nama (	First, Middla, Last)			18. Mothar's Nama (First, Middla, Maidan Sumama)							
To	FRANCESC	O SECONDA	ARI		ARISTEA PALMIERI							
umar I	19a. Informant's Na	me/Ralationship (	Type, Print)		19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip						Code)	
	ANNA S. SECONDARI/SPOUSE 518 NORTH MAIN STREET, BOONSBOR							BORO, MARYLAND 21713				
	20a. Mathod of Disp			CON	ce of Disposition (A	ama of other place	)	Dala	20c. Location -	City or To	wn, Stata	
	1 MBurlal 2 Cramation 3 Ramoval from Stata 4 Donetion 5 Other (Specify)  Cematary, cramatory or other place)  BOONSBORO CEMETERY  11/11/00 BOONSBORO,										MARYLAND	
	21. Signature of Fur	naral Sarvice Licen	See 2 59 V	0.0		and Addras						
	D Ch	even Dani	Folt Im	Myles	BAST 1	TUNERA	L HOME	7606 01				
	23a. Part1. Enlar th shock, or haar	na disaasa, or com	plications that caus	ed tha daath.	Do not antar tha m	oda of dying	, such as cardiac	Boonsbo or raspiratory ar	rast,	yrand	Approximata	
ın	shock, or haar	t failura. List only	ona causa on aach	lina.							Onsal and Death	
i	Immediata Causa (I		CI	Andre	NO STOWN		Orlina	CON	. OIS ED	8.3	VE DO 5	
10	disease or condition rasulting in death)  a. (HICANC OB)TRUTIVE POLITICATION PORTO DISCOST ACIDADO											
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ledical	rasulting in death) L	ast conditions co	d	Dua to (or a	is a consequence of a consequence of the consequenc	(Ex L7):			/		o the cause of death?	
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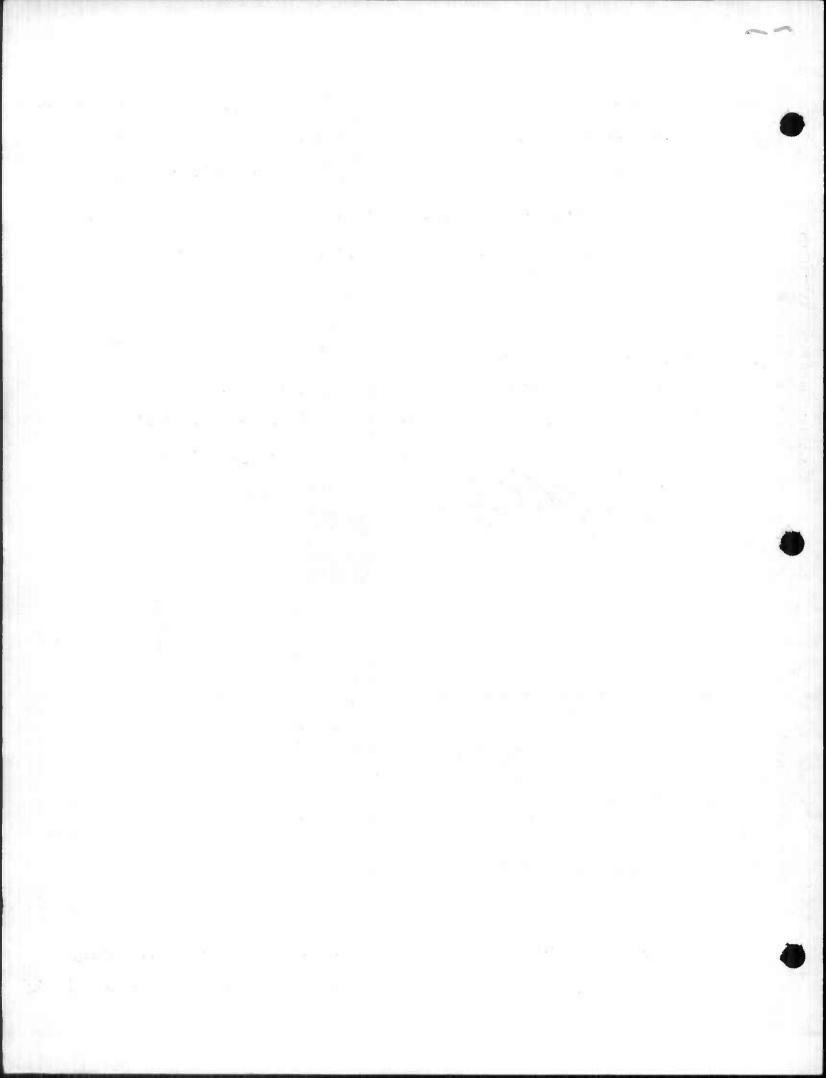
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State of Maryland / Department of Health and Mental Hygiene 0 0 37436

			Ce	rtificate of	Death	F	Reg. No.			
	1. Decedent's Name (First, Middle, La	est)				2. Date of Dea		3. Time of Death		
Physician	CLARENCE TROXE	II. SEWARD				Month NOVE	MBER 13,	2000 10:05		
/Medical Examiner	4a Facility Nama (If not institution, gir				4b. City, Town, o	Location of Death	-			
Fyanninei	PAVENTIOOD III	THERN VILLAGE		7000	HAGER	STOLIN	TAC	UTNOTON		
F		Sex 7. Age (In yrs	. last birthday	If Under 1 Yaar		s. 8. Date of Birth		HINGTON  Birtholace (State or Foreign)		
Funeral Director	Months Days Hours Min.						(, Year)	Birthplace (State or Foreign Country)  FOR NITOCINITA		
Director	Usual Residence of Decedent							9, 1912 WEST VIRGINIA		
ž u	10a. Stata 10b. County	10c. C	ity. Town or L	ocation				10d. Inside City Limit		
H show	MADAT AND LIAGUEN	ICITION			HACEDOR	OF TAT		1X Yas 2□N		
or 28s-f a	MARYLAND WASHIN	IGION		10f, Zip Code	HAGERST		10g. Citizen of Wh	et Country?		
				101. Zip 0006						
r tems 23a or 28a niner must be not Funeral Direc	1183 LUTHER DRIVE				21740		U.S.			
	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Maxican, Puerto					Specify Yas or No- rto Rican, etc.)		American Indian, White, etc.		
F.	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:			
E 5	3 Widowed 4 Divorced Yaar or Dates:						ороспу.	WHITE		
te net	15. Decedent's E (Specify only highest gro	ducation	16a. Dece	edent's Usual Occu	pation	orkina	16b. Kind of Busin	ness/Industry		
y within piene.	(Specify only highest grada completed)  (Giva kind of work done during most of working life. DO NOT use retired)  (Giva kind of work done during most of working life. DO NOT use retired)									
	8		PA	INTING CO	NTRACTOR		PAI	INTING		
	17. Father's Name (First, Middle, Last	)		4 10 - 17		eme (First, Middle,	Maiden Sumame)	n Sumame)		
S S S S S S S S S S S S S S S S S S S	WILLIAM RICHARD S	SEWARD			BESSIE	(UMN) DA	WSON			
Pages 1 and 2 should be filed elief of Health and Mental Hyg nt: If Item 27 la marked otherry or other traumatic event.	19e. Informant's Name/Relationship		19b. Meil	ing Address (Stree		Rural Route Number		ate, Zip Code)		
	C. ROBERT SEWARD							LAND 21742		
	20a. Method of Disposition		_	osition (Name of	IRAIL,	Date	20c. Location - Ci			
	1⊠ Burial 2 ☐ Cremation 3 [			emetory or other pla	ice)	1				
ury uny	4 Donation 5 Other (Special	יונון	AVER C	REEK CEME	CTERY	11/16/00	HAGERST	OWN, MARYLANI		
mportant: any injury	21. Signature of Furneral Service Coerces  Paul M. Dean  P									
Departme Importan any Injur	MILAND	Paul M. D	ean B	AST FUNER	RAL HOME					
	BOONS DOTO, MARY.  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									
vsician	shock, or heart failure. List only one cause on each line.									
ledical	Immediate Cause (Final	PIACTONIA	tom.		01	0		1 100		
aminer	disease or condition resulting in death)	a. GASTRO 11 Dua to	V/667	INHL	1361212	D		6 MOINTHS		
e e								9.11		
ng ng ng		b. AORTIC			٠ .			2 years		
sician and burial-transit	Sequentially list conditions, if any, leading to immediate	^	or as a conse					2 years		
	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that infiliated events  Due to (or as a consequence of):  OANICINS OW DISTERS  Due to (or as a consequence of):									
physician is the buria edical E	that initiated events resulting in death) Last Due to (or as a consaquance of):									
M eing	d.									
d by the attendietached for us.										
Sic Sic	Part il. Other significant conditions	23b. Did tobacco use contributa to the cause of d								
id be detached to d by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.						1 □ Yes 2 □ No 3 □ Probably 4 ₺ Unk			
o de de			-							
page 2 should be d						24a. Was	an autopsy med?	24b. Were autopsy finding available prior to		
should should						perio	imed?	completion of cause of death?		
hes ge 2										
Com						10)	res 2/8-No	1 ☐ Yas 2 ☑ No		
is certificate director, par To Be Co	25. Was case referred to medical examiner?	Moneiteli				eeth (Check only o				
in d	1 Ves 20 No	l	☐ ER/Outpatie	ent 3LI DOA		Homa 5 Rasid				
her the	27. Menner of Death  1 □ Vetural 5 □ Panding	28a. Date of injury (Month, Day Year)	28b. Tima o	of 28c. Inji	ury at ork?		now injury occurred	1		
atte	2 Accident Investigation		An	1AM 10	Yes 2□No		NIA			
at Director: After the funeral of in by the funeral Certification:	3 Suicida 6 Could not to determined		home, farm, st	treet, factory, office		28f. Location (S City or Tox		or Rural Route Number,		
d de	A COMMOND	building, alc. (Space	NIA	+		0.0, 0.70	WI Stele)			
A fille	29a. Certifier (Certifying Pt	nystcian: To the best of my kn	owledge, dee	th occurred at the	ime, dete and pla-	ca, and due to the		ner as stated.		
Pietely file		niner: On the basis of examinand manner stated.								
with the strough and open.  To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29b. Signature and title of certifier			29c. Licer	se number		29d. Date signed	(Month, Day, Year)		
5 E 8	1/10 1000	9 1,0	1							
	and the	1/100	1	0	-856 S	>	11.12 0	0 '		
	30. Nama and address of person who	completed cause of death (Its	23a) (Type	, Print)	0.1		-1-	0. MD2174		
	MANZAR. 3	5-5 (+AM/	368	Agill	Stree	1- Hag	rg (Zun	1707174		
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	- 4	6 /-	11					
Registrar	NOV 1 A	2000 Dener	1	papa	us					



Physic		1. Decedent's Nama (First, Middla, Last	)	20.01	ficate of		2. Data of Deat		3. Time of Deeth
/Medi		Florence Leor	a Shank					per 11	,°2000 12:35
Exami		4a. Facility Nama (If not Institution, give Williamsport N	street end number) Jursing Hom	е		4b. City, Town, or L William		4c. County Wash	of Death ington
Funeral Director		213-34-0733	7. Aga (In yrs		Under 1 Year Ionths Deys	if Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Mar . 31	^Y 1 ⁸ 908	Birthplace (State or Fore Country)     MD
puel puel		Usual Rasidance of Decedant  10a. Stete 10b. County		ity, Town or Locati	ion				10d. Insida City Lim
Mery Iffed tor	tor	MD Washing	ton	Clear S	pring,				<b>X</b> □ Yas 2 □ I
or 28	Director	10e. Street and Number	10	Vhat Country?					
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	eted	15. Decedant's Edu (Specify only highast grad	cation e completed)	18a. Decedant	's Usual Occup d of work dona	ation during most of work	king	16b. Kind of Bu	sinass/industry
	Jdmc	Elementery/Secondary (0-12)	HO	NOT usa ratire memake	during most of world)		resi	dence	
	Be Co	12th grade 17. Fathar's Name (First, Middle, Last)	U			18. Mothar's Nam	a (First, Middla, N	falden Surnam	a)
should be filed nd Mental Hygi marked other imatic event,	To B	Charles De	nnis			Leila			
Heel Heel Heel Heel Am 2		19a. Informant's Name/Raiationship (7) Rodney L. Shan				and Number or Ru			
		20a. Mathod of Disposition		Place of Disposition	on (Nama of				City or Town, Stata
		1 Burial 2 Cramation 3 F 4 Donation 5 Other (Specify)	lamoval from State R	ose Hil	ory or other plant 1 Cem.	Nov. 15	,2000	lear :	Spring, MD
permit. Peges Department of Important: If its any injury or o		21. Signature of Fureral Service Licens	10	Don	ame end Addra	lwin Tho	mpson F	unera	l Home, Inc
		23s. Parti. Enter the disease or compl shock, or heart failure, dist only or	cations thet caused the dea	P.O ath. Do not anter the	BOX 3	10 Clea	r Sprin	ig, MD	Approximata
hysician		shock, or heart failure dist only of	na causa on each lina.						triterval Between Onset end Deeth
/Medical Examiner		Immediata Cause (Final disaasa or condition rasulting in deeth)	Alzheime	r's Disa	ase				years
	ē		Due to	(or as a consaquar	nce of):				1
cuted	amlı		Due to						
executed in and deliransit		Sequentially list conditions.	Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disasse or thing.)						
oriah a		Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disasse or Injury							
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centificate be executed nding physician and use as the burial-transit	edical	Sequentially list conditions, if any, teading to Immediate causa. Enter Underlying Cause (Disaese or Injury that initieted events rasulting in death) Last		or es e consequen	ce of):				
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attendir for use	edical	Part II. Other significant conditions cor	itributing to death but not ra	sulting In the unda	rlylng causa giv		23b. Did tol	/	ntribute to the cause of deal
attendir for use	by Physician/Medical	Part II. Other significant conditions cor	itributing to death but not ra	sulting In the unda	rlylng causa giv		1 ☐ Ye	autopsy	3 Probably 4 Unknot
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ine lew requires mat me deem cer ate has been signed by the attendir page 2 should be deteched for use	To Be Completed by Physician/Medical	Part 11. Other significant conditions con  Hypertension, Re  Tract In Fecture  In sufficiency  25. Was casa refarred to medical axaminar?  1 Yas 2 No	itributing to death but not ra  nal Insuffi  ns Anemia  Topital: 1   Inpatlant 20	sulting in the undar	Rena 30 DOA Oth 28c. injur	28. Placa of Dea	1 Ye  24a. Was ar perform  1 Ya  th (Check only one one 5 Reside 28d. Describe ho	a autopsy ned?  s 2 No  n nee 6 Other winjury occurrence and Numbir	3 Probably 4 Unknown  24b. Ware autopsy finding available prior to completion of causa of daath?  1 Yes 2 No
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requires that the deem cell sen signed by the attendir should be deteched for use	edical Certification: To Be Completed by Physician/Medical	Part II. Other significant conditions con  Hypertension, Re  Tract In Fectur  In sufficient conditions con  Re  Tract In Fectur  In sufficient conditions con  In sufficient conditions con  Re  Tract In Fectur  In sufficient conditions con  In sufficient conditions conditions conditions con	intributing to death but not range of the control o	Sulting in the under  CPCY  due 40  DEP/Outpatlent  28b. Tima of Injury  noma, ferm, street, if/y  owledge, death ocetion and/or invast	rlying causa given and a control of the control of	28. Place of Dealer: 4 Versing Heyat k? Yas 2 No	24a. Was ar perform  1  Ya  th (Check only one ona 5 Reside 28d. Describe ho  28f. Location (Str. City or Town and dua to the cared at the time, de	s 2 No  a autopsy ad?  s 2 No  a)  nce 6 Oths w injury occurr  reet and Number usa(s) and ma ate and plece, s  dd. Date signed	3 Probably 4 Unknow  24b. Ware autopsy finding available prior to completion of causa of daath?  1 Yes 2 No  ar (Specify)  ed  er or Rural Routa Number,  nnar as stated. and dua to tha causa(s)



ate of Maryland /	Department of Health and Mental	Hygiene	1
	Certificate of Death	Reg. No.	U

Physician /Medical Examiner
Euporal

Mildred H. Smith 4a Fecility Name (If not institution, give street end number) Caroline Nursing Home

1. Decedent'a Name (First, Middle, Last)

Nov. 4b. City, Town, or Location of Death Denton

Day 2000 0249 4c. County of Death

5. Social Security Number

7. Age (In yrs. last birthday) 1 M 2 X F 215-05-1437

If Under 24 Hrs. If Under 1 Year Days Months Hours

Caroline Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year)

Director

28a-f show

Items 23a or must be

natural, or

Hygiene.

permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygiens
Important: If Item 27 is marked other tha
any Injury or other traumeter

72 hours after

Baltimore, Maryland 21215-0020

Funeral

À

Completed

Be

Usuel Residence of Decedent 10a State 10b. County Caroline

10c. City. Town or Location

87

Yrs.

Jan. 2, 1913

6

2. Date of Death

Month

Maryland 10d. Inside City Limits

37438

3. Time of Death

MD Director

10e Street and Number

10f. Zip Code

1 XYes 2 No

21643

Approximate Interval Between Onset end Deeth

11 Marital Status

520 Kerr Avenue

21629

10g. Citizen of What Country? United States

1 Never Married 2 Married 3 ₩ Widowed 4 Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

Denton

Bleck White, etc. White Specify:

16b. Kind of Business/Industry

14. Race - American Indien,

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator

Plastic Production

17. Father's Name (First, Middle, Last)

Stanley Strannahan

18. Mother's Neme (First, Middle, Maiden Sumeme) Nannie Willoughby

19a. Informant's Name/Reletionship (Type, Print) Virginia Moxey/Daughter 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6409 Suicide Bridge Rd., Hurlock, MD

20a. Method of Disposition DBurial 2 Cremation 3 Removal from State

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Hill Crest Cemetery

Date 20c. Location - City or Town, State 11/8

Federalsburg, MD

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses

Golson 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Framptom-Hawkins-Eskow Funeral Home, PO Box 43, Federalsburg, MD 21632

**Physician** /Medical Examiner

physician and s the burial-transit

98 lor usa as USB

signed I

page 2 s

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director,

To the Hosp within 24 ho To the Fune completely fi

The law requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760.

Examine

Physician/Medical

Completed by

Be

Medical Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

Immediate Cause (Final disease or condition resulting in deeth)

ongestive hear De to (or es e consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

1Dertension

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yea 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Menner of Deeth 5 Pending Investigation

6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year)

28b. Time of 28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Deeth (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1. Neturel

2 Accident

3 Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number U0047534 29d. Date şigned (Month, Day, Year) 61 00

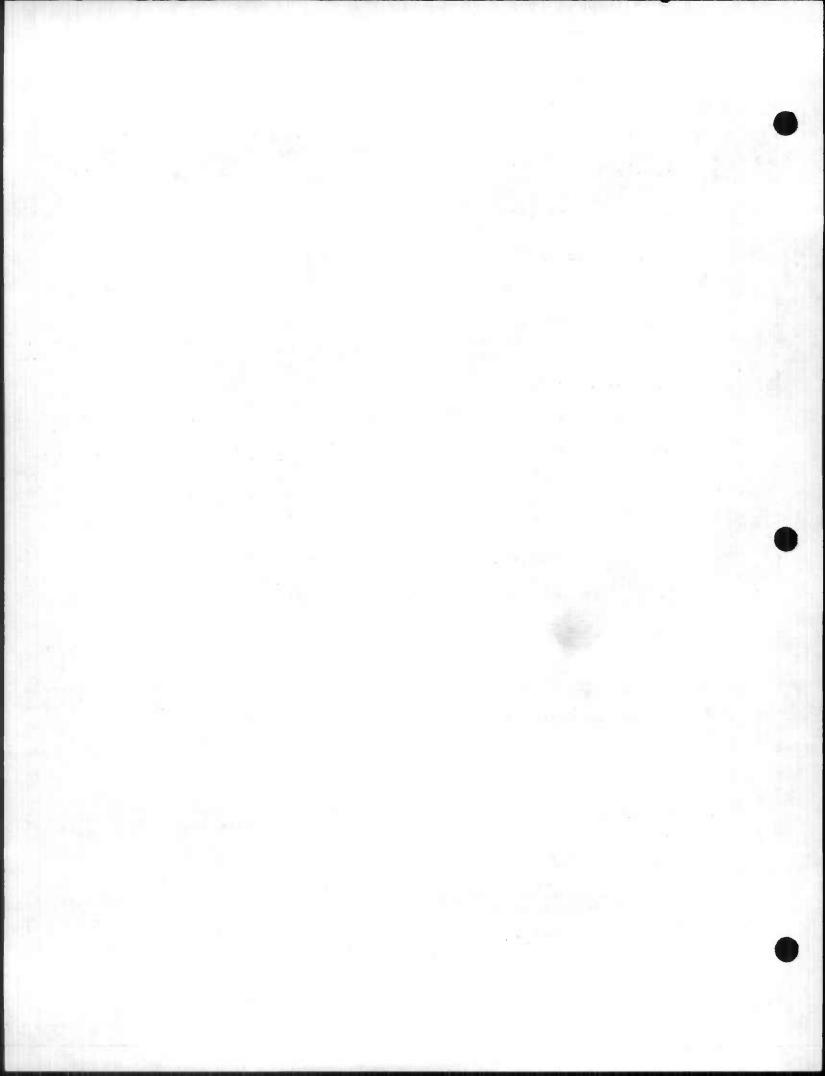
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wafik Zaki, 920 Market M.D. Denton, MD 21629 St.,

28e. Plece of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

State Registrar

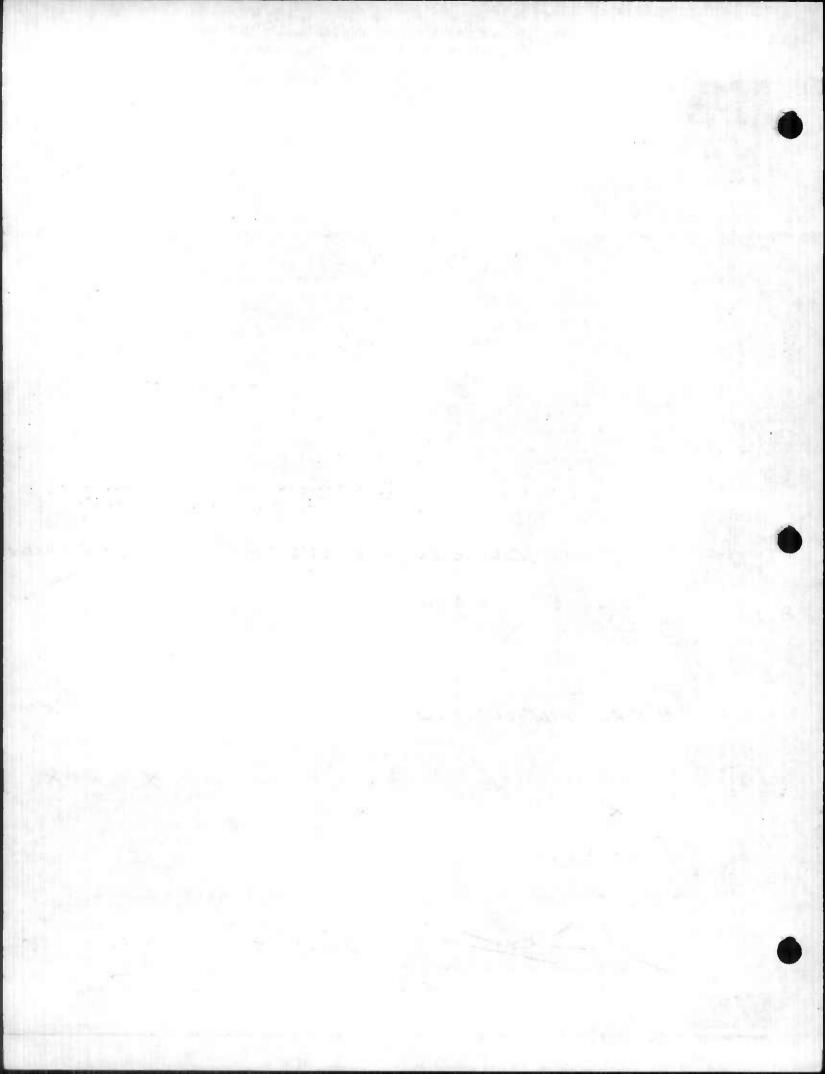
31. Dete filed (Month, Day, Year) NOV - 8 2000 32. Registrar's Signature



	Ce	ertificate of Death	Reg. No.								
Di	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death								
Physician /Medical	ASHBY AMOS SHORT	Nov. 9,20	00 0150								
Examiner	4e Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death 4c. Co	unty of Death							
	Memorial Hospital Easton	Easton		albot							
eral ctor	5. Social Security Number 2 1 6 - 7 4 - 0 6 1 3 6. Sex 1 M 2 F 7. Age (In yrs. last birthday,	If Under 1 Yeer   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Dey, Year) Aug. 28, 19:	9. Birthplace (State or Foreign Country) 34 Maryland							
	Usual Residence of Decedent  10e. State 10b. County 10c. City, Town or L.	ocalion		10d. Inside City Limits							
th with the Maryli 23a or 25a-f sho at be notified at al Director	MD Caroline	Federals	burg	1 ☐ Yes 2√ No							
	10e. Street and Number 5646 Federalsburg Highway	10f. Zip Code 2 1 6 3 2		ed States							
Examinar mat	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U,S.  Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 No Specify:	Rican, etc.)	Race - American Indian, Black, White, etc. Pecity: White							
edical	15. Decedent's Education 16e. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	ina 16b. Kind	of Business/Industry							
up du	Flementary/Secondary (0-12) College (1-4or 5-)	e kind of work done during most of work DO NOT use retired)		N/A							
ed within	0	sabled									
Sc even Fo Be	17. Father's Name (First, Middle, Last) Ernest Earl Short	Gertru	une (First, Middle, Maiden Sumame) ude V. Larrimore								
-	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street end Number or Flur	al Route Number, City or T	own, State, Zip Code) 21632							
5		16 Federalsburg									
nt of Hear It if Rem r or othe		osition (Name of smatory or other place) rest Cemetery		ralsburg, MD							
Part .		2. Name end Address of Facility	, ,	w. 30 w. 3, 110							
ans ans	Mulail 7-Eskon-	ramptom-Hawkins	ralshura l	neral Home, PA							
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
ician				Interval Between Onset and Death							
dical	Immediate Cause (Final disease or condition a. CEREBRAL Free It is a condition a. CERE	HEMORR HAGE		2 12 WEEK							
miner	resulting in deeth)  Due to (or as a conse			E BY SHEET							
ii a											
s the burial-transit	Sequentially list conditions,  Due to (or as a conse	equence of):	Managhe								
E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.										
edical	Cause (Disease or injury c										
4	d.										
by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Pert I.	23b. Did tobacco us	e contribute to the cause of death							
Phy	ATRIAL FIBRILLATION	1 Yes 2 No 3 Probably 4									
b od	AIRIAL PIBRILLATION										
should			24a. Was an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?							
irector, page 2 5 Be Comp			1 □ Yes 2 🖎								
	25. Was case referred to medical	26 Place of Deat	h (Check only one)								
irector	examiner? 1   Yes   2   No		ome 5 Residence 6	Other (Specify)							
. 9	27. Manner of Death  1 Matural  5   Pending (Month, Day Year)   Injury		28d. Describe how injury of								
After function	1⊠Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No									
Funeral Director: After this in filled in by the funeral director Certification: To	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, si building, etc. (Specify)	treet, factory, office	28f. Location (Street and I City or Town, Stete)	Number or Rural Route Number,							
O OF	29a. Certifier Certifying Physician: To the best of my knowledge, dee										
plately III	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, deeth occur	red at the time, date and pl	ace, and due to the cause(s)							
To the comple	29b. Signature and tyle of certifier	29c. License number	29d. Date :	signed (Month, Day, Year)							
	1001	DOU53815	11/9	7/2000							
-	10. Name and address of pareas who completed arrive of death (flow 50-) (7.			/							
-	30 Name and address of person who completed ceuse of death (Item 23a) (Type										
	Korah Pulimood, M.D. 510 S.	5th Ave., Dent	on, MD 216	29							
State		1									
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrar's Signature NOV 1 4 2000	bak)									

DHMH 16 Rev 6/95

**ORIGINAL** 



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37440 Amended item#4c, per MD, 11/09/00, SRR, Talbot Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October. 12:58 P.M. JANET MULLEN MARIE 2000 /Medical 4c. County of Death 4a Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death Examiner Talbot WAShinsted 7. Age 21 TENS+on 1508 STUD FUND If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1□M 257F 52 Director 220-48-3507 -18-48 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director MA ERSTON ALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 items 23s 21601 USA 1508 WASHINGTON 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No
II Yes, Give
Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours aft Department of Heelih and Mental Hygiana. In proclamt: if Itam 27 Ia marked other than "natural", or any Injury or other traumatic avant, the present of the pages. Baltimore, Maryland 21215-0020 1 ☐ Yes 2 M No Specify: by BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) LINE WORKER BLACK // 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be MAE BANNARD C. GROSS KOLAND GROSS 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PARKWAY EASTON, MO, 21601 29520 GROSS MICHAEL - 50 N DABIN 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Burial 2 Cremation 3 Removal from State RICHARDSON CEMETARY 11/16/2000 EASTON, MD. 4 □ Donetion 5 □ Other (Specify) 21. Signature of Furierel Service Licensee 22. Neme end Address of Fecility BENNIE SMITH FIH 426-DOVER ST. EASTON Mp. 21601 23a. Pert1. Enter the diseesa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betw Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical Due to (or as e consequence of): 950 Part I/Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 12 es 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2) No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medicel examiner?
1 □ Yes 2 □ No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending Invastigation 1 Netural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifiar (Check only one)

State Registrar

enniter 31. Dete liled (Month, Dey, Year) NOV 0 9 2000

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print)

29b. Signature-and title of certifier

Hollywood 32 Registrer's Signature

400

506 Idlewild Ave. Easton, Md.

29d. Date signed (Month, Day, Year)

70.176

Amended Item #26, Per Phy., 11/08/2000, Carroll County, cew Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended Item #20b, Per F.D., State of Maryland / Department of Health and Mental Hygiene 11/09/2000, Carroll Co., cew Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) November 4, **Physician** 2000 MARGARET ELIZABETH STONESIFER 2:00 a.m. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner 6410 Keysville Road Keymar Carroll If Under 24 Hrs. 8. Date of Birth Month, Pay, Year) NOV. 12, 1915 7. Age (In yrs. last birthday) If Under 1 Yaar 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 10 M 20 F Mary Tand 84 213-18-6889 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show 1 Yes 2 No Carroll Keymar Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6410 Keysville Road 21757 USA 238 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 X No Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Hygiene. Clothing Elementary/Secondary (0-12) College (1-4or 5+) Manufacturer Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked or Emory Null Mamie Bollinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 is Department of Health ar Important: if item 27 is any injury or other trau 6408 Keysville Rd., Keymar, MD 21757 Doris McGlaughlin/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal Irom State Keysville, MD Keysville Union Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility 21. Signature of Funeral Service Licenses 136 E. Baltimore St. Keles 21787 M00534 Skiles Funeral Home Taneytown, MD 23a Part / Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, about, or heart lailure. List only one ceuse on each line. Approximata Intervel Between Onset and Death **Physician** Immediate Causa (Final disaasa or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of defith? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Donknown Division of Vital Records. Be Completed by 24b. Were autopsy lindings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yas 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; within 24 hours after death.

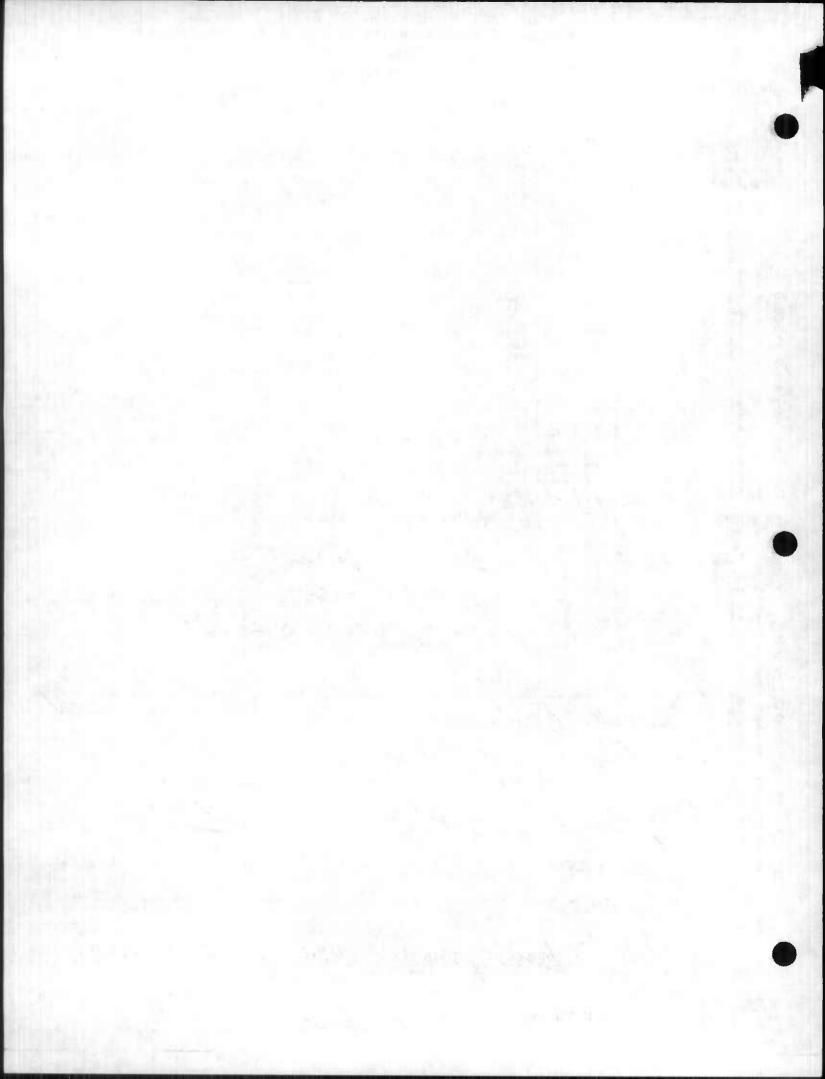
To the Funeral Director: After this certifica completely filled in by the funeral director, p 5. Was case refe 26. Place of Death (Check only Other: 4 Nursing Home Hospital 21340 1 Inpatient Medical Certification: To 1 Yes 3 DOA 6 ☐Other (Specify) 27. Manne of Death 1 Natural
2 Accident 5 Pending Investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the ceuse(s) and manner steted. 29a. Certifier 29c. Licanse number ath (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

09

2000

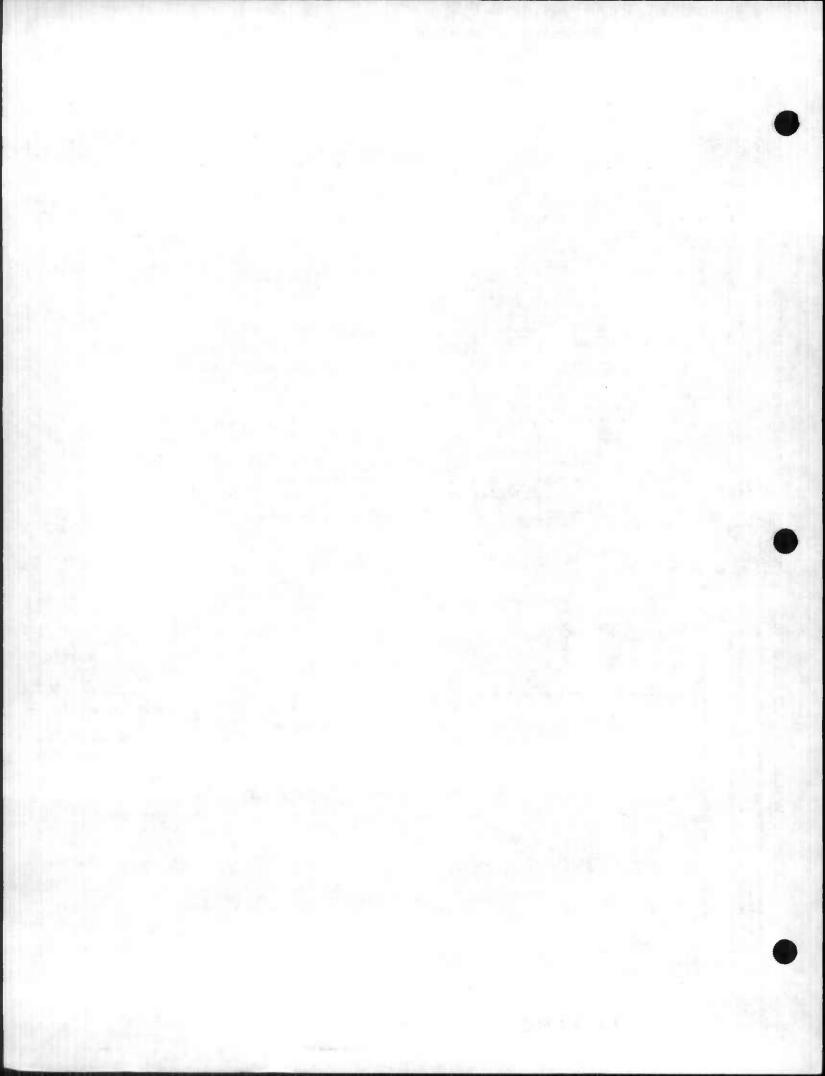


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State of Maryland / Department of Health and Mental Hygiene

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	Certificate of Death	Well 1-3	Reg. No.						
	Decedent's Name (First, Middle, Last)	2. Date of De	ath Dey Yeer	3. Time of Death					
ysician Medical	James Bradley Strouth	Novembe		10:30PM					
aminer	4a Facility Name (If not institution, give street and number)  4b. City, Tow	n, or Location of Death	4c. County of Deat	h					
	ozado incidendo	sville		erick					
al or	5. Sociel Security Number 228-14-8725  6. Sex 1 Months 7. Age (In yrs. last birthday) 83 Yrs.  1 Months Days Hours	Min. (Month, De	of Birth, Dey, Year) 2.4, 1917  9. Birthplece (State or F Country) Virginia						
	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits						
*				1 ☐ Yes 2 🛣 No					
Directo	Maryland Frederick Union Bridge  10e. Street and Number 10f. Zip Code		10a Chizon of What Co	unter?					
110.555	10248 Fountain School Rd. 21791		10g. Citizen of Whet Country? U.S.A.						
at, or harm 23a or 28a-t show Examiner must be notified at by Funeral Director	11. Meritel Stetus  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Sive Yeer or Detes: 1942-45	in? (Specify Yes or No Puerto Rican, etc.)							
	15. Decedent's Education (Specify only highest grade completed)  16e. Decedent's Usuel Occupation (Give kind of work done during most life. DO NOT use retired)	nt wadding	16b. Kind of Business	Industry					
Completed	Elementery/Secondery (0-12) College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)		park & planni						
				miling Commi.					
a			ne (First, Middle, Maiden Sumeme) ia Miller						
10				7: Codel					
27 is m r fraum	19e. Informent's Neme/Reletionship (Type, Print)   19b. Meiling Address (Street and Number   10248 Fountain Scho								
	20a. Method of Disposition  20b. Pleca of Disposition (Neme of cemetery, cremetory or other place)	Date	20c. Location - City or	Town, State					
	4 Donetion 5 Other (Specify) Resthaven Mem. Gardens		Frederick,	MD					
Man	21. Signature of Funerel Service Licensee . Xarbar 11802 Liberty Re	Hartzler Fu d. Libert	neral Home tytown, MD	21762					
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart feiture. List only one cause on each line.	ardiac or respiretory e	rrest,	Approximate Interval Between					
				Onset end Death					
1	Immediate Cause (Final disease or condition resulting in deeth)								
1.5	Due to (or as a consequence of):								
Examiner	b								
Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.								
edicai	Inet initieted events  Due to (or as a consequence of):								
Med	resulting in death) Lest								
Physician/M									
ysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.			to the cause of death?					
by Pi			108 2/2010 50 6	Tobably 4 Olikilow					
Completed b			ormed?	Were autopsy tindings available prior to completion of cause of death?					
mc		10	Yes 22 No	1□Yes 2□No					
	25. Was case referred to medical 26. Piece	of Deeth (Check only of		10,100 10,100					
o Be	exeminer?		denca 6 □Other (Spe	ocify)					
-	27. Menger of Death  1 Neturel 5 Pending (Month, Dey Year)  28b. Time of Injury work?  1 Accident investigation (Month, Dey Year)  28c. Injury et Work?  1 Yes 2	28d. Describe	how injury occurred	(City)					
Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location ( City or To	Street and Number or R wn, State)	urel Route Number,					
edical C	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and check only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.	I place, end due to the h occurred at the time,	cause(s) and menner e date end pleca, end du	s stated. e to the cause(s)					
X.	29b. Signeture end title of certifier 29c. License number		29d. Dete signed (Mon						
	Michael Lerner Mo D416	19	Novembe	- 6,2000					
	30. Nama end address of person who completed cause of death (Item 23e) (Type, Print)								
		lkersville	. MD 21793						
State	31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture		, = 1//3						
gistrar	NOV 0 8 2000 Denera & Sparks								

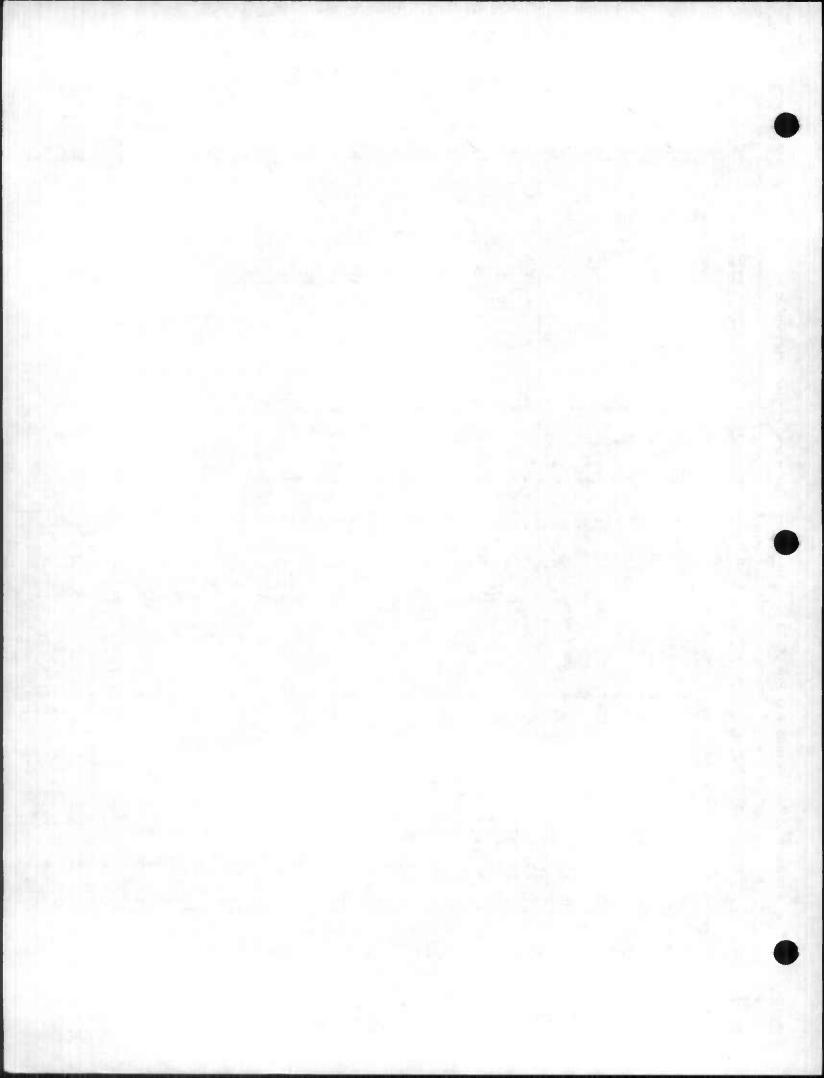


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State of Maryland / Department of Health and Mental Hygiene

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						Ce	rtifica	te of	Death			Rea. No.			
			. Decedent's Nama (First, Middle, La	st)					4 3 1	20 11	2. Date of De			3. Time o	ot Death
	Physicia	_	Campbell H	louk Smi	th.	Jr				60	Nov	6. Day	2000 Year	193	16
	/Medica	4	a Facility Name (If not institution, giv					4	4b. City, Tov	vn, or Lo	cation of Deat	-	County of Death		10
	Examine	r e	Carroll County (			1			Wes	tmin	ster		Carro		
1-		5	Social Security Number 8. S		A	last birthday)	If Unde	r 1 Yaar	If Under 2		P Date of Bir	th			or Foreign
L	Funeral Director		218-10-4372  Usuel Residence of Decedent    Name							0	nplace (State intry) NESSEE				
	D R.		Oa. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside (	City Limits
	Vany tab	ò	Maryland Carr	m11				Н	ampste	ead				1 🗆 Yas	s 2 No
	020 Ins after death with the Ma if, or have 23a or 28a-1a learniner must be notified by Funeral Director	9	De. Street and Number			-	101.7	p Code				10a Citi:	zen of What Cou	intry?	
			1700 North Main	Street					210	74	USA				
21215-0020		DÀ	Marital Status     Nevar Married 2∑ Married     Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yas 2 The Yes, Giva Year or Dates:	No				lispanic Orig an, Mexican Specify:	gin? (Spo , Puerto	pecify Yes or No- D Rican, etc.) 14. Race - An Black, Wi Specify:				
5-0	72 ho	Completed	15. Decedent's Ed			16a. Dece	dent's Usu	al Occup	ation	of work	ina	16b. Ki	nd of Business/I	ndustry	
2	We all	- Die	(Specify only highest grade completed)  (Give kind of work done during most of working the first product of the fi						119						
	N G G A	0	11				Sup	ervi	sor				Koppers	Compa	iny
P		99	7. Father's Name (First, Middle, Last)						18. Mothe	r's Neme	(First, Middle	Maiden	Sumeme)		
Maryland	To E								Wells						
an	and and		9a. tnformant's Neme/Reletionship (	Type, Print)		19b. Maili	ng Addres	s (Street	and Numbe	r or Aura	Aoute Numb	er, City o	r Town, Stete, Z	ip Code)	
2	Date a		Mildred Smith, v	vife		170	0 Nor	th M	lain S	t, H	ampstea	ad, N	D 21074		
altimore	More, and of He and of He world He was of He w	2	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Greenmount Cemetery								1/09/ 000	Date 20c. Location - City or Town, State /09/			
Balti	Departm Departm Importar any Inju	2	1. Signature of Funeral Service Licer				2. Name a	nd Addre	ss of Facility	/ E	line F	ınera	-		
		-	23a. Part1. Enter the disease, or com shock, or heart lailure. List only	To Cal	ar						_		וא כוניו , ו	Approxima	
68760,	Certificate be executed ding physician and use as the buriel-transit		isease or condition esulting in death)  sequentially list conditions, any, leading to immediate ause. Enter Underlying Jausa (Disease or injury nat initiated events esulting in deeth) Lest	ь. <u>Ас</u> ь	D09 10 (01	r as a consecutive as a	quence or,		ma.	de	a /dy	sch	Shown	30,	, XV2
Box	for for	Physiciarym	dPart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death?				
P.0	5 60 .	, ruy	COPD Hyper Land in the underlying cause given in Part I.							1 Yea 2 No 3 Probably 4 thinno				20 nknown	
Records	seen s hould	Completed by									24a. Was	an autop ormed?	8	Vare autopsy vailable prior completion of death?	rto
	sician: The lew s certificate has b sirector, page 2 s	E									10	Yes 2	aNo 1	☐ Yes 20	□ No
Vital	ifical or, p		5. Was case referred to medical				-		26 Place	ot Dootl	(Check only				
5	Physician: this certific	מ	examiner?	Hospitel:	0.54	ER/Outpatier	-1 200	Oth Oth	or.				DONNA (Cana	-26.a)	
on of	2 4	2	7. Manner of Death  1 Natural 5 Pending  2 Accident investigation	1 ☐ Inpatii 28a. Date ol Inju (Month, De		28b. Time o Injury		28c. Injur Wor			28d. Describe		S Other (Spec y occurred	ту,	
Division	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Z Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Plece of In building, et	ury - At ho c. (Specify	me, tarm, str	reet, lacto	ry, office			28t. Location ( City or To		d Number or Ru )	ral Route Nu	mber,
	Hospit     24 hour     Funers     Jetely fille			ysician: To the best niner: On the basis o and manner st	f examinat										(s)
	To the		9b. Signature and title of cullifier	011			29	c. Licans	e number	I D		29d. Dat	e signed (Montt	, Day, Year)	
			1//	111		ne		1)0	050	410	2	1	1/8/0	0	
		2	D. Name, and address of person who,	completed sever of	loath (lts:	230\/T	Drint	0		, , ,			10/0		
		3	Michael	completed ceuse of c	MI)	238) (Type,		21-	ence I	0	Westn	20.13/		11.57	
	State	3	1. Date liled (Month, Day, Year)	32. Registr	ar's Signal			1	4				0	, )	
	Registra		NOV 0 8 20	IND NOW	wa	19	de	Day N	1						



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Funeral

Director

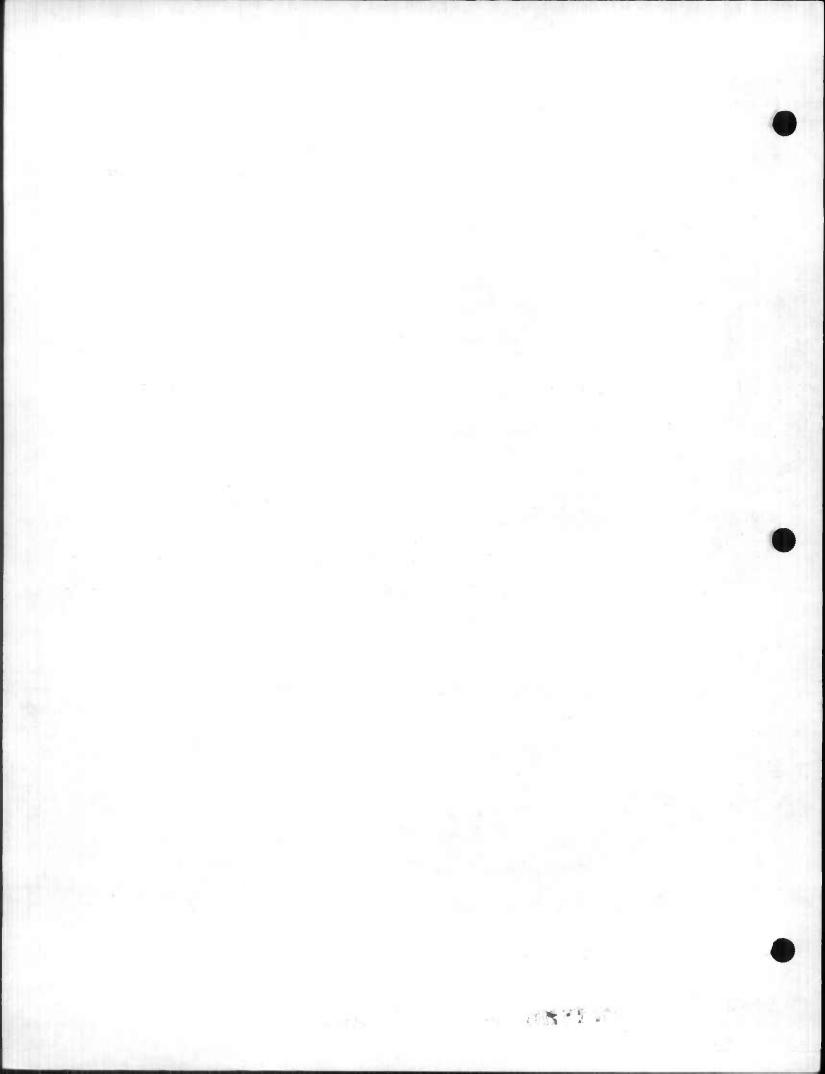
/Medical Examiner To the Hospital or Attending Physician: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Usuel Rasidance of Decedant  10a. Stete  10b. County  Maryland  Charles  10e. Street and Number  3047 C October Place  11. Meritel Status  1 Nevar Married  1 N	Months  or Location  Waldorf  10f. Zip C  13. Was Decede If Yes, specif 1 Yes, specif (Giva kind of work lifa. DO NOT use  Salesman  Meiling Address (C)	Polyson Days  Code 20 ant of Hi fy Cubai  CXNo  Occupe c done do retired,	Hunder: Hours Hours  602 spanic Origin, Mexican Specify:	Poin 24 Hrs. Min. Min. Min. Min. Min. Min. Min. Min	8. Date of Bird (Month, Da OCT 16	Day ER 14 4c. Count (1) 109. Citizen of US. 14. Ra	Cecil 9. Birthe Court Ohic	plece (Stata or Foraigntry)  10d. Inside City Limit  1
VA MARYLAND HEALTHCARE SYSTEM  5. Social Security Number  232 70 1172  Usuel Rasidance of Decedant  10a. Stete  10b. County  Maryland  Charles  10c. City, Town  Maryland  Charles  10 Street and Number  3047 C October Place  11. Meritel Status  1 Nevar Married  1 Nevar Married  1 Nevar Married  1 Specify only highast grade completed)  Elemantary/Secondary (0-12)  College (1-4or 5+)  2 S  17. Father's Name/Reletionship (Type, Print)  Margaret R. Stewart  19a. Informant's Name/Reletionship (Type, Print)  Margaret R. Stewart (Mother)  20a. Mathod of Disposition  1 Buriel  2 Constant Status  1 Decedent's Education  (Specify only highast grade completed)  Elemantary/Secondary (0-12)  College (1-4or 5+)  2 S  17. Father's Name (First, Middla, Last)  John E. Stewart  19a. Informant's Name/Reletionship (Type, Print)  Margaret R. Stewart (Mother)  20b. Place of I comparity  Trinit  21. Signature of Funaral Sarvice Licensaa  M00173  Mo0173	Months  n or Location  Waldorf  100. Zip 0  13. Was Decede If Yes, specif 1 Yes, specif (Giva kind of work Iffa. Do NOT use  Salesman  Meiling Address (C)	Polyson Days  Code 20 ant of Hi fy Cubai  CXNo  Occupe c done do retired,	Hunder: Hours Hours  602 spanic Origin, Mexican Specify:	Poin 24 Hrs. Min. Min. Min. Min. Min. Min. Min. Min	NOVEMBI cation of Death t 8. Date of Bin (Month, Da OCT 16	ER 14 4c. Count 4c. Count 4c. Count 1946	2000 y of Death Cecil  9. Birth Ohic  Whet Court	plece (Stata or Foraigntry)  10d. finside City Limit  t □ Xras 2□ N  ntry?
VA MARYLAND HEALTHCARE SYSTEM  5. Social Security Number  232 70 1172  Usuel Rasidance of Decedant  10a. Stete  10b. County  Maryland  Charles  10c. City, Town  Maryland  Charles  10 Was Decedent Evar in U.S. Armed Forcas?  1 Nevar Married  1 Never Married  1 Nevar Married  1 N	Months  n or Location  Waldorf  100. Zip 0  13. Was Decede If Yes, specif 1 Yes, specif (Giva kind of work Iffa. Do NOT use  Salesman  Meiling Address (C)	Polyser Days  Code 20 ant of Hi fy Cubai  CXNo  Occupe c done do retired,	Hunder: Hours Hours  602 spanic Origin, Mexican Specify:	Poin 24 Hrs. Min. Min. Min. Min. Min. Min. Min. Min	8. Date of Birn (Month, Da OCT 16	1946 10g. Citizen of US.	Cecil 9. Birthy Cour Ohic Whet Cour A	plece (Stata or Foraigntry)  10d. Inside City Limit  1
5. Social Security Number  232 70 1172  Usuel Rasidance of Decedant  10a. Stete  10b. County  Maryland Charles  10c. Street and Number  3047 C October Place  11. Meritel Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Education  (Specify only highast grade completed)  Elemantary/Secondary (0-12)  College (1-4or 5+)  2 S  17. Father's Name (First, Middla, Last)  John E. Stewart  19a. Informant's Name/Reletionship (Type, Print)  Margaret R. Stewart (Mother)  20b. Place of Commeton  1 MB uriel 2 Crametion 3 Removal from Stata  1 Popation 5 Othar (Specify)  21. Signature of Funaral Sarvice Licensaa  M00173  Immediata Causa (Finel disease, or complications that caused the death. Do not specify on the printing of the print	Months  n or Location  Waldorf  100. Zip 0  13. Was Decede If Yes, specif 1 Yes, specif (Giva kind of work Iffa. Do NOT use  Salesman  Meiling Address (C)	Code  20 ent of Hi fy Cubal  (XNo  Occupa  c done de retired)	Hours Hours Hours Hours Hours Hours	24 Hrs. Min. Min. gin? (Spe,, Puarto	8. Date of Bird (Month, Da OCT 16	1946 10g. Citizen of US.	9. Birthy Cour Ohic Whet Cour A	plece (Stata or Foraigntry)  10d. Inside City Limit  1
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Maryland Charles  10e. Street and Number  3047 C October Place  11. Meritel Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highast grade completed)  Elemantary/Secondary (0-12)  College (1-4or 5+)  2  17. Father's Name (First, Middla, Last)  John E. Stewart  19a. Informant's Name/Reletionship (Type, Print)  Margaret R. Stewart (Mother)  20a. Mathod of Disposition  1 MBuriel 2 Crametion 3 Removal from Stata 4 Ponation 5 Othar (Specify)  21. Signature of Funaral Sarvice Licensaa  M00173  Margaret Reletionship or Complications that caused the death. Do not specify, or heart fellura. List only ona cause on each line.	Waldorf  10f. Zip 0  13. Was Decede If Yes, specif 1 Yes 34  Decedent's Usual (Giva kind of work lifa. DO NOT use  Salesman  Meiling Address (CO11 E Pri	20 ent of Hi fy Cuba  QNo  Occupe c done de retired,	spanic Origin, Mexican  Specify:	, Puarto	cify Yas or No	US. 14. Ra Bla	Whet Cour	t □Xras 2□ N ntry? can Indien,
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3047 C October Place  11. Meritel Status  1 □ Nevar Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  15. Decedent's Education (Specify only highast grade completed)  Elemantary/Secondary (0-12)  College (1-4or 5+)  2 S  17. Father's Neme (First, Middla, Last)  John E. Stewart  19a. Informant's Name/Reletionship (Type, Print)  Margaret R. Stewart (Mother)  20a. Mathod of Disposition  1 ☑ Buriel 2 □ Crametion 3 □ Removal from Stata 4 □ Ponation 5 □ Other (Specify)  21. Signature of Funaral Sarvice Licensaa  M00173  Mountail Causa (Finel disease, or complications that caused tha death. Do not specify only on a cause on each line.	13. Was Decede If Yes, specif 1□ Yas ¾ Decedent's Usual (Giva kind of work Iffa. DO NOT use Salesman  Meiling Address (	20 ent of Hi fy Cuba  QNo  Occupe c done de retired,	spanic Origin, Mexican  Specify:	, Puarto	cify Yas or No	US. 14. Ra Bla	A ce - Americ	can Indien,
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2 S  17. Father's Neme (First, Middla, Last)  John E. Stewart  19a. Informant's Name/Reletionship (Type, Print)  Margaret R. Stewart (Mother)  20b. Place of I cematary  1 Buriel 2 Crametion 3 Removal from State 4 Donation 5 Othar (Specify)  21. Signature of Funaral Sarvice Licensaa  MOO173  23a. Fatt. Entar the disease, or complications that caused the death. Do not spock, or heert feillura. List only one cause on each line.	Meiling Address (			or worki	ng			
John E. Stewart  19a. Informant's Name/Reletionship (Type, Print)  Margaret R. Stewart (Mother)  20a. Mathod of Disposition  1 M Buriel 2 Crametion 3 Removal from State 4 Ponation 5 Othar (Specify)  21. Signature of Funaral Sarvice Licensea  MOO173  23a. Fart. Enter the disease, or complications that caused the death. Do not speck, or heart fellura. List only one cause on each line.	011 E Pri					Medica	1 Equ	ipment
19a. Informant's Name/Reletionship (Type, Print)  Margaret R. Stewart (Mother)  20a. Mathod of Disposition  1 M Buriel 2 Crametion 3 Removal from Stata  4 Ponation 5 Other (Specify)  21. Signature of Funaral Service Licensea  MO0173  23a. Fart 1. Enter the disease, or complications that caused the death. Do not speck, or heart fellura. List only one cause on each line.	011 E Pri	1.	18. Motha	r's Nama	(First, Middle,	Meiden Sumei	ma)	
Margaret R. Stewart (Mother)  20a. Mathod of Disposition  1 M Buriel 2 Crametion 3 Removal from Stata  4 Population 5 Other (Specify)  21. Signature of Funaral Service Licensea  MO0173  23a. Faft I. Enter the disease, or complications that caused the death. Do not speck, or heart feilure. List only one cause on each line.	011 E Pri		Marga	ret	Harden	Stewar	t	
20a. Mathod of Disposition  1 Mauriel 2 Crametion 3 Removal from Stata 4 Population 5 Other (Specify)  21. Signature of Funaral Service Licensea  M00173  23a. Pott. Enter the disease, or complications that caused the death. Do not spock, or heert fellura. List only one cause on each line.		(Street a	and Numbe	or or Rura	I Routa Numbe	er, City or Town	, Steta, Zip	Coda)
1 M Buriel 2 Crametion 3 Removal from State 4 Denation 5 Other (Specify)  21. Signature of Funaral Service Licensea  MOO173  23a. Part 1. Enter the disease, or complications that caused the death. Do not speck, or heart fellura. List only one cause on each line.			A1be	ert S	quare 1	Waldorf	, MD	20602
21. Signature of Funaral Sarvice Licensaa M00173  23a. Farti. Entar the disease, or complications that caused the death. Do not spock, or heert fellura. List only one cause on each line.  Immediate Causa (Finel disease or condition ASPIRATION PNET)	Disposition (Name y, cremetory or oth		в)		Data	20c. Location	- City or To	own, Stata
23a. Part : Entar the disease, or complications that caused the death. Do no spock, or heart fellura. List only one cause on each line.  Immediate Causa (Finel disease or condition ASPTRATTON PNET)	ty Memori	ial	Garde	ns 1	1-16-0	) Waldo	rf, M	D
Immediata Causa (Finel disaasa or condition ASPTRATTON PNET)	22. Name end			E		n Funer te Pls.		
Immediata Causa (Finel disaasa or condition ASPTRATTON PNET)							, 1111	Approximate
disaasa or condition ASPTRATION PNET								Intarval Between Onsat and Death
rasulting in death)	JMONIA						1	l week
Dua to (or as a co							1	
b. HUNTINGTON'S CH							i	30 years
Sequentially list conditions, if any, laeding to immadiate cause. Entar Undarfying	onsequence of):						1	
Cause (Disaase or Injury that initiated events	ouzeoneuce ut).				_			
rasulting in death) Last								
Pert II. Other significant conditions contributing to death but not resulting in	the underlying cau	use give	en in Part I.		23b. Did	obacco use co	ontribute t	o the cause of death
SEIZURE DISORDER					10	Yes 20 No	3 Pro	bably 4 Unknow
					24a. Was perfo	en eutopsy med?	6V	fere autopsy findings vailable prior to empletion of cause death?
					10	ras 21 No	t	□Yas 2□No
25. Was casa raferred to medical			26. Placa	of Death	(Check only o	na)		
axaminer?  1 Yas 2 No Hospitel: 1 Inpatient 2 ER/Outs	tpatient 3 DOA	Othe	Mr.			dence 6 □Ot	her (Speci	(v)
27. Mannar of Death 28a. Dete of Injury 28b. Tir		c. Injury		1		now injury occu		,,
3 Suicide 6 Could not be determined 28e. Place of Injury - At homa, fam building, afc. (Specify)	m, street, factory,	office		1	28f. Location (S City or Tox	Street and Num vn, Stata)	ber or Run	al Routa Number,
29a. Cartifiar (Check only one)  Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner steled.	death occurred at Vor invastigation, in	t tha tim	e, dete and plnion, deat	d place, a	and due to tha	causa(s) end m data and place,	annar es s and dua t	itated. o tha causa(s)
29b. Signature and title effort fier	29c.	License	number			29d. Date sign	ed (Month,	Day, Year)
M	т	0202	15			OVEMBE	2 1/1	2000
30. Nama and addrass of person who completed causa of death (Item 23a) (T		1202	J. J			AO A ENIDET	14	2000
KARMACHANDRA NAIR, M.D., VA MARYLAN		ממסנ						

**DHMH 16 Rev 6/95** 

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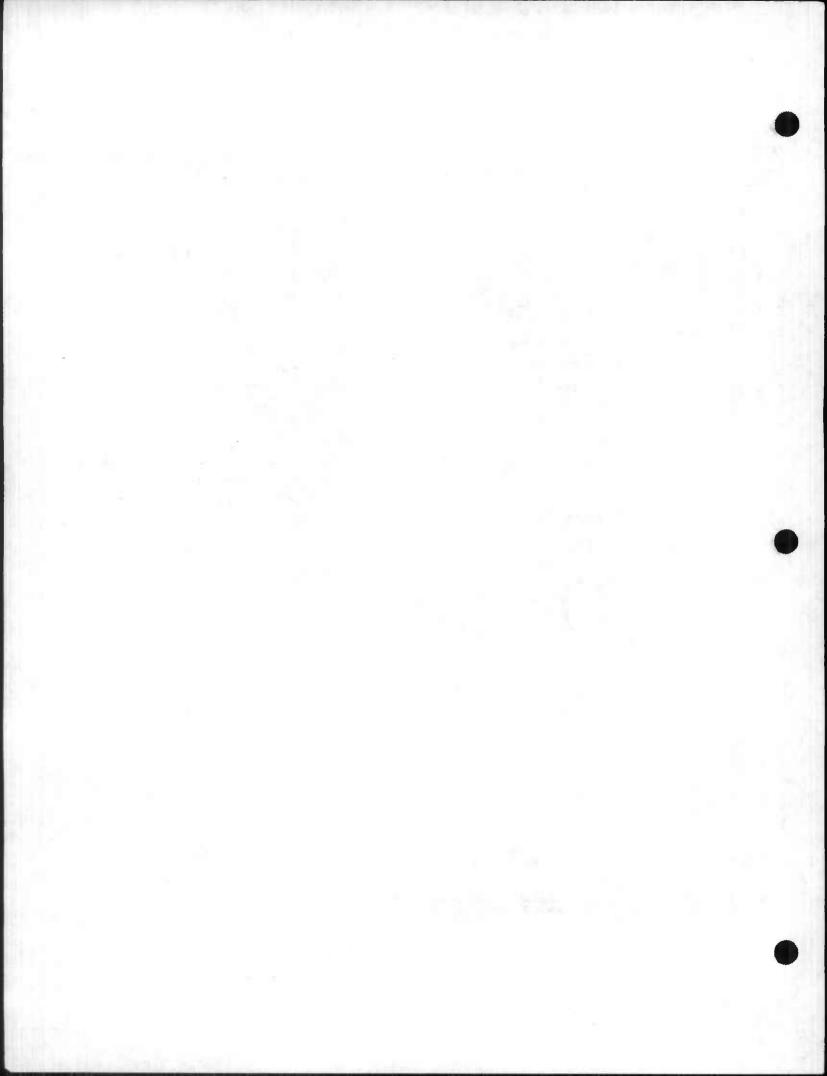
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	State of Maryland / Department of Health and Mental Hygiene	1	li li	-

D	EAN SCOI	T em	SESSA 23a,27, 28a,b,c,d,ef,	State of Maryla					Mental Hy	giene U L Reg. No.	) 3	1445
			1. Decedent's Name (First, Middle, Last)					-	2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medica		Dean Scott Ses	ssa						17, 2000		7:46 PM
	Examine		4a Facility Name (If not institution, give the HOWARD COUNTY GE		r <b>a</b> l		4	b. City, Town, or COLUMB I	Location of Deat	HOWA		
	Funeral Director		5. Social Security Number 6. Sec. 217–90–7965	7 LO 0 L	rs. last birth 31 Yr	Months	Year Days	If Under 24 Hr. Hours Mir		y, Year)		place (State or Foreign htry) vland
	the Maryland r 28a-f show inotified at	ector	10a. State 10b. County  Maryland Howard	10c.	City, Town o	riottsvi						0d. Inside City Limits 1 ☐ Yes 230 No
	with the ser 2	Dir	10e. Street and Number  12107 Mayapple	Trail		10f. Zip 0				10g. Citizen of United		
	G 22 B	era		12. Was Decedent Ever in	US			isnanic Origin? (	Specify Yes or No			can Indian,
020		by Fun	Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	0,0.	If Yes, specif		n, Mexican, Puè Specify:	Specify Yes or No rto Rican, etc.)	Bia Specif	ck, White,	
15.0	rether	Completed	15. Decedent's Edu (Specify only highest grade		16a. D	ecedent's Usual Give kind of work ife. DO NOT use	Occupa done	ation during most of w	orking	16b. Kind of B	usiness/In	dustry
212	yens.	omp	Elementery/Secondery (0-12)	College (1-4or 5+)		upervisc		,		Gallowa	ay Po	ol Co.
g	四十五日.	Bec	17. Father's Neme (First, Middle, Last)	Production of				18. Mother's Na	me (First, Middle		_	
/lar	uld be Mental rhead of	10	Loenard Sessa					Barba	ara Cos	sentino		
Maryland 21215-0020	and 2 sho sith and 1 27 is ma ir trauma		19e. Informent's Name/Reletionship (Ty Leonard Sessa / d	pe, Print) Father					Rural Route Numb L Marri			
Baltimore	Pages 1 a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			Disposition (Neme crematory or oth EWN Memo			Nov. 21 2000	20c. Location Marriot		own, State
Balt	Depart Depart Import any inj ance		21. Signature of Funeral Service License		1096	Harry H	Addraw d C	itzke's	Family : Pike El	Funeral licott (	Home	, Inc. MD. 21043
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	NARCOTIC INT	OXICAT		of dyin	g, such as cargi	ac or respiratory a	irrest,		Approximate Intervel Between Onset and Death
	P =	ner		Due ic	(01 85 9 00	risequence or).					1	
68760,	ysicia ne bur	9	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			nsequence of):						
Вох	ath ce	and									1	
P.0.	that the ed by the detached	/ Physician/Med	Part II. Other significant conditions con	tributing to death but not r	resulting in t	he underlying ca	use giv	en in Part I.		Yes 2 (No	3 Pro	o the cause of death'
Vital Records,	2 50 .	Completed by								s en autopsy ormed?	8/	fere autopsy findings vailable prior to ompletion of cause death?
Re	The law ate has page 2	E							i je	Yes 2□No	1	Pes 2□ No
ta	certificate rector, pag	9	25. Wes case referred to medicat examiner?					26. Plece of D	eeth (Check only	one)		(
of <	00	0	1 No Yes 2 No	lospital: 1   Inpatient 2	EXER/Outp		Oth	er: 4 Nursing	Home 5 ☐ Res	idenca 6 □Ot	her (Speci	fy)
ion c	Attending Ph ir death. ector: Affer th by the funeral		27. Menner of Death  1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury fourith. Dey Year, 11/17/00		ne of P 28	c. Injur Wor 1 🗌	yet k? Yes 2.Ē∰o	28d. Describe unknow	how injury occu	rred	
Division	tal or Attenders attanders de in by ti	Certification:	3 ☐ Suicide 6 ☑ X X Sould not be determined	28e. Place of Injury - A building, etc. (Spe found: resident	home, fam cify) dence	n, street, factory,	offica		City or To	(Street and Num own, State) 903 , Marylan	6 Farl	al Route Number, y April Way
	Hospi 24 hou Funer tely fill	edicai		sician: To the best of my ker: On the basis of exam- and manner stated.								
	To the To the Compie	2	29b. Signature and title of certifier	1 An	40			e number .M.E		29d. Date sign.		Day, Year)
		1	30. Name and address of person who co	mpleted cause of death (I	tem 23e) (T	ype, Print) Penn Str	eet	, Baltin	nore, Mar	ryland 2		
			1141104 15.16	111 Vichil								

Registrar

filed (Month, Day, Year)
NOV 2 0 2000



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 37446

	Certificate	of Death	Re	g. No.	
Division	Decedent's Nama (First, Middla, Last)		2. Data of Death Month		3. Time of Death
Physiciar /Medica	TOTA PIARTE STEVENS		Novembe		000 11:55 AM
Examiner	As Escility Name /// not institution size street and number)	4b. City, Town, or L		4c. County of D	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	PCOMORE  Year   Hundar 24 Hrs.  Bays   Hours   Min.	-	Worce Yeer) 9.	Birthplaca (Stata or Foraign Country)
Director	217-28-3454 1 M 2KJ F 69 Yrs. Worter's Usual Residence of Decedent		May 7, J	1931	Maryland
hend wo	10a. Stata 10b. County 10c. City, Town or Location				10d. Inside City Limits
the Maryle 28e-f show notified at	Maryland Worcester Pocomoke City	7			1 ☐ Yes 2 🛣 No
fier death with the Marylend r thems 23s or 28s-f show liner must be notified at	10e. Street and Number 2836 Sheephouse Road	ode 21851	10	g. Citizen of What USA	Country?
ter death	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent If Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexican, Puart	pecify Yas or No-		American Indian,
Urs	3 ☐ Widowed 4 ☐ Divorced Year or Datas:	/	o racan, etc.)	Specify:	White, etc.
72 hours	15. Decedant's Education 16a. Decedent's Usual C (Specify only highest grade completed) (Give kind of work of	ecupation	king 1	6b. Kind of Busine	ess/Industry
	Elementary/Secondary (0-12) College (1-4or 5+)	done during most of work etired)	, , ,	D /	
nd 212 e filed withing all Hygiene. outher than vent, me.				roduct	100
Maryland 3 should be flie 4 should be flie 5 should be flie 7 should be flie To Bac	17. Father's Name (First, Middle, Last)	18. Mothers Nam	ne (First, Middle, M	11.1	
Maryland de 2 should be filed in end Mental Hyg 7 is marked other traumatic event,	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (8	Treat and Number or Pu		City or Town Stal	
Mar nd 2 sho ith end ith end i	7076 Shand	01	Pocomok		MD 2/85/
re, of Healt item 2	20b. Place of Disposition (Neme cemetery, crymetory prothe	NO. 11.		Oc. Location - City	or Town, Stete
Pages nent of int: If its	1 Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify)	Prosteria	11/13/00	Pocomok	City MD
Baltimore, N permit. Pages 1 and Department of Health Important: if Item 27 any injury or other to once.	1 000 -11 - 17 18 N	address of Facility  Melsun F-	H	1 July 10 K	E Olog III
4040	Michael H. Dean 103 Lin	den Ave	Pocamo,		MD 21851
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac	or respiratory arre	st,	Approximate Intervet Between Onset and Death
Physician / /Medical	Immediate Cause (Final M. 4-1+: R.	A Car	ren		
Examiner	disease or condition resulting in death)	1	TENC		13715
ر کسسی	Due to (or as a consequence of):				
oxecuted in end instrument	Sequentially list conditions,  Due to (or as a consequence of):				1
od / 60, cata be executed physician end s the burial-transit					1
	that Initiated events resulting in death) Last Due to (or as a consequence of):				
5 0 6	d				
dS, P.O. BOX sires that the death certi signed by the attending d be detached for use a				241	1
the day	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause	e given in Part I.		1	bute to the cause of death?
- 50 -			1 Ye	2 2 KNo 3	☐ Probably 4 ☐ Unknows
Kecords, le law requires to has been signinge 2 should be			24a. Was an		4b. Wara autopsy findings available prior to
The law require rate has been single 2 should			periorii	leur	completion of ceuse of death?
			1 ☐ Ya	s No	1 Yas 20 No
sicien: The certificate lirector, pag	25. Was case referred to medical	26. Place of Des	ith (Check only one	3)	
<u> </u>	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing H	ome 5 Resider	nce 6 Other (	Specify)
n OT ng Phys ther this meral d		Injury at Work?	28d. Describe ho	w injury occurred	
UNISION C belor Attending P is after death. at Director: After t led in by the funera Certification.	2 Accident investigation 3 Suicide 6 Could not be	1 Yes 2 No			
OIVISION OV Attending after death. Director: After d in by the fune	28e. Place of Injury - At home, ferm, street, factory, o building, etc. (Specify)	flice	City or Town,		or Rural Route Number,
To the Hospital or Attending Physiph 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Madical Certification:	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at	ha time data and place	and due to the on	weefs) and mann	ar as stated
he Hospit in 24 hour he Funer pletely fill	(Check only 2 Medical Examiner: On the bast of examinetion and/or investigation, in one)	my opinion, death occu	rred at the time, da	ite end plece, and	due to the cause(s)
To the		icense number	29	d. Date signed (M	fonfh, Dey, Year)
F 3 F 3		12627	78	11/131	100
	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)	10001		11	
12	DAVID COURLY MD 145 E. Carroll	St	Salish	any,	21801
State	31. Data filad (Month, Dey, Year) 32. Registrar's Signature				
Registrar	NOV 1 4 2000 Januar G. Son	a Na			

Please Type or Print in Biack Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Pauline Thomas 12:01AM November 2, 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital

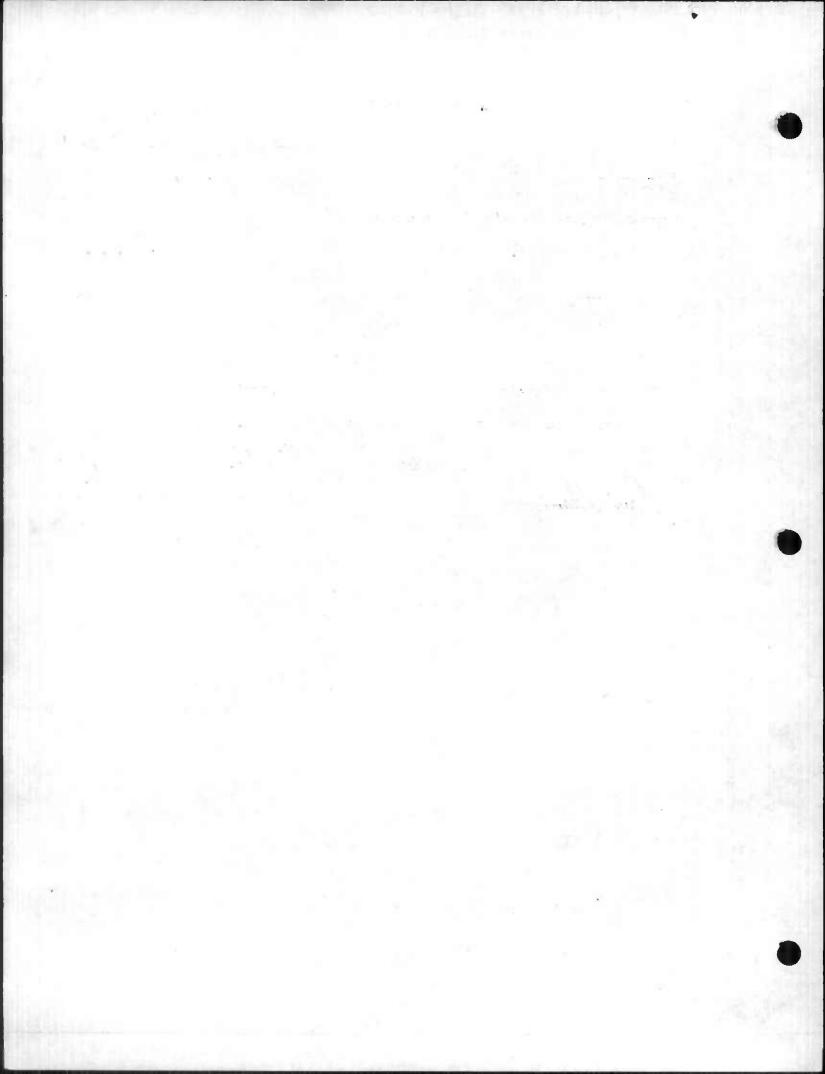
5. Sociel Security Number 6. Sex 7 Prince George's Clinton If Under 24 Hrs. If Under 1 Yeer 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Min. Days Months Hours 1 M 75 F 73 Yrs Director Dec. 23,1926 513-20-8807 Kansas 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow the Medical Examinar must be notified at Temple Hills 1 ☐ Yes ¾☐ No Maryland Prince George's Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 U.S.A. 3705 Spring Terr. Funeral death Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? Bieck, White, etc. 72 hours after 1 Yes 2 Your Year or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White þ XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Home traumatic avent. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 Is marked oth any Injury or other traumatic avent page. Carol Weidner Frederick Grater 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 6205 Quarles Road St. Leonard, Maryland 20685 Susan Whittemore (Daughter) 20b. Place of Disposition (Neme of cemetery, cremetery or other piece Nov. 13,2000 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Duriel 2 Cremetion 3 Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland State Veterans Cem. Cheltenham, Maryland 21. Signatural Funeral Service Licensee 22. Name and Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 Mans aus c Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) · ACUTE MYOCARDIAL INFARCTION /Medical Examiner Due to (or es e consequence of): Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that inflieted events resulting in death) Last Due to (or es e consequence of): 68760 Physician/Medical 8 Due to (or es e consequence of): -3 Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown B ğ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 20No 25. Was case referred to medical Be 26. Place of Deeth (Check only one) 150 es 2 No Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Meturel 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital Within 24 hours a To the Funeral C completely filled Medical Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted. 29e. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier And k. Mahagen. mD D50689 11/2/2000 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) SOUTHERN MARYLAND HUSDITAL ANIL K. MAHAJAN. CLINTUN MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

Registrar

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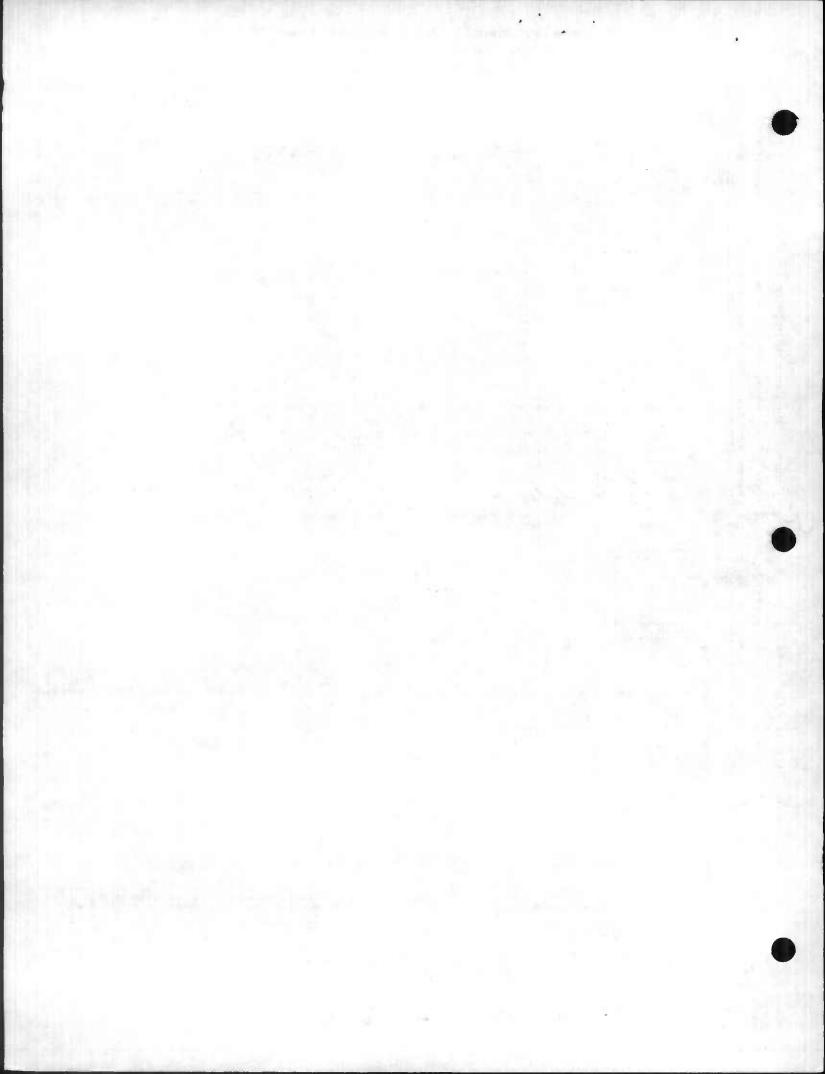


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State of Maryland /	Department of Health and	Mental Hygiene

				Cen	tificate of	Death	Re	g. No.			
		1. Decedent's Nama (First, Middla, La		1000			2. Date of Death		Vaar	3. Tima of	
	Physician (Madical	Joh	n F. Tillett				Novembe:	r 3,200	)Qaar	12:15	PM
	/Medical Examiner	4a Facility Name (If not institution, given	ra street and number)			4b. City, Town, or I	ocation of Death	4c. County	of Death	7000	
N.		Bradford Oaks Nu	rsing&Rehab.	Center		Clinton		Princ	e Geo	orge's	
	Funeral	5. Social Security Number 6. 5	Sax 7. Age (In )	rrs. lest birthdey)	If Under 1 Yea Months Days		8. Date of Birth (Month, Dey, 6/26/20			ace (Stata or	
	Director	577-38-3674	M 2□ F 80	Yrs.	month buy		6/26/20		Washi	ington	,DC
	9 .	Usual Residence of Decedent	100	City, Town or Loc	antion				100	d. Insida Cit	he I imite
	show and	10a. State 10b. County							10	1 TYes	
	or 28a-fr be notified	Maryland   Anne Ar	undel l	Edgewater							X
	Dir.	10e. Street end Number			10f. Zlp Code	027	10	)g. Citizen of V		ıyτ	
	and the state of t	300 Orchard Road		110		1037		USA	a - America	n Indian	
Maryland 21215-0020	72 hours star death with the Maryta natural; or items 23s or 28s-f show final Examiner must be notified at sted by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant Ever in Armed Forces?  1 □ X Yes 2 □ No 1/  If Yes, Give  Year or Dates:	JULT	Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puart o Specify:	o Rican, etc.)	Blac	k, White, e	tc.	
5-0	72 h	15. Decedent's E (Specify only highest gr	ducation	16a. Decede	ent's Usual Occi	upation a during most of wo	kina	16b. Kind of Bu	siness/Ind	ustry	
21	od within 72 ho ygiene. er then *neturn t, the Medical.	Elementary/Secondary (0-12)	College (1-4or 5+)			a during most of wor red)					
2	Cor the	8th		Pai	inter			Const		on	
Pu	B series	17. Father's Name (First, Middle, Last					ne (First, Middle, N		18)		
yla	Men	John E. Tillett					. Seller:	-			
Aar	2 sh Is m	19a. Informant's Name/Relationship	Type, Print)		g Address <i>(Stree</i>	et end Number or Ru	irel Route Number,	City or Town,	State, Zip	Code)	
	fealth m 27	Richard Tillett/		b. Place of Dispos		elli 10	Date 2	20a Location	City or Toy	m State	
altimore,	10 m	20a. Method of Disposition  1 Derial 2007 Demation 3 D	Removal from State	cemetery, crem	etory or other p		1000	20c. Location -			
tim	tamen tamet dury	4 Donation 6 Other (Speci				matory 11				VA.	
Sal	Semilary long loss	21. Signeture of Funeral Service Lice	gsee/	Ge Ge	Name and Add	ress of Facility Kalas Fu	neral Hor	ne. P.A			
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Division	Attending or death.  • ctor: After by the funa iffication	2 Accident Invastigation 3 Suicida 6 Could not be determined	One Diseased beings	At home, farm, stre			28f. Location (St	reet and Numb	er or Rure	Route Num	ber,
D.		4 Homicide	building, etc. (Sp	ecify)			City or Town	, State)			
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	within 2 To the comple	29b. Signature and title of certifier	Ar	~/	29c. Lice	nse number	29	9d. Date signe	d (Month, L	Day, Year)	
	->	1///	-a/2	1	D-2	24535		11/4/2	000		
	(4)	30. Name and address of person who	completed cause of death (	Item (3a) (Type F	Print)						
	U	Laxmi Berwa, M.D	. 7700 Old Br	anch Ave	. Clint	on, Md. 2	0735				
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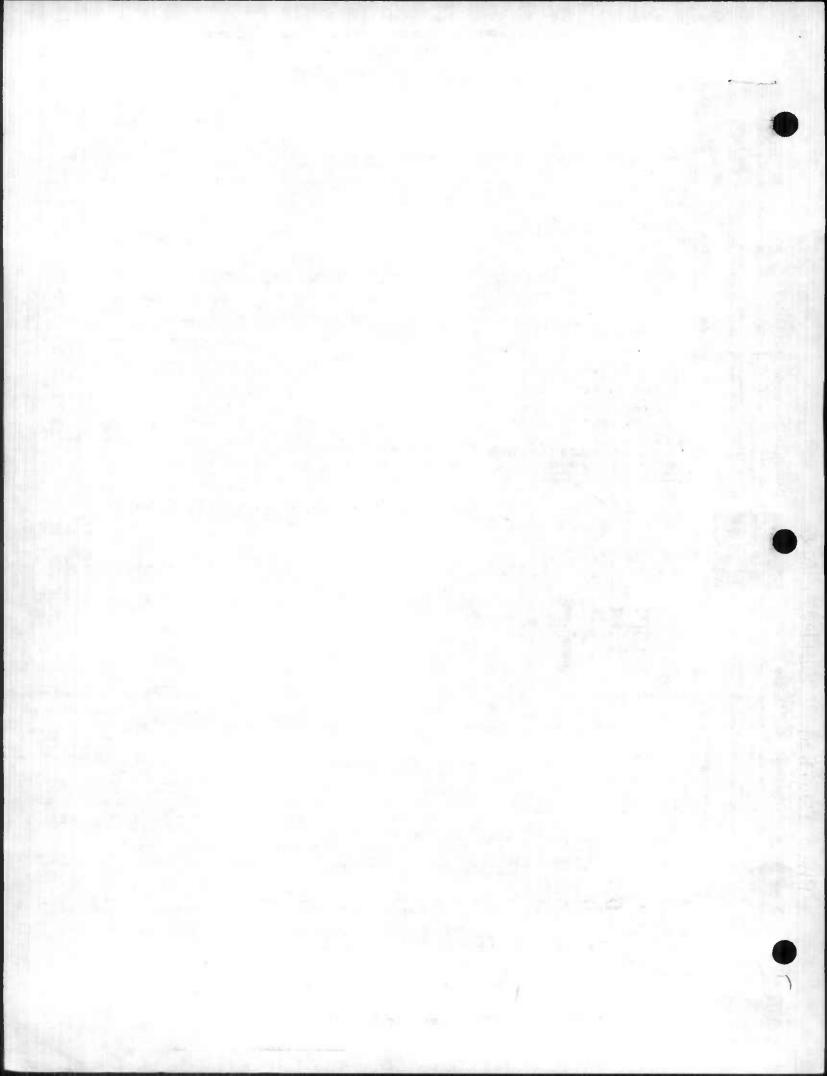
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					Ce	nificati	e or	Death		R	leg. No.		
	ician dical	Decedent's Name (First, Mide     Phan Duy	die, Last) Tran								r 31, 2		3. Time of Death 12:02 PI
	niner	4e Facility Name (If not institution Suburban Hos		imber)					hesd	cation of Death	4c. County	of Death	CV.
Funer Direct	_	5. Social Security Number 220–53–1918	6. Sex 1 M 2 F	7. Age (In yrs. Id	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of Birth (Month, Day Dec. 08	Year)		place (State or Foreigntry)
D	-8	Usual Residence of Decedent											
with the Marylend a or 28a-f show	Director	Virginia Fai  10e. Street and Number	rfax		enna		Codo				Og. Citizen of		0d. Inside City Limi 1   Yes 2 N
with or	ក់	903 Kramer C				10f. Zip							myr
death w	eral	11. Marital Status		edent Ever in U.S	5. 13.		2180 lent of t	lispanic Or	igin? (Spe	ecify Yes or No-	Viet		an Indian,
5 2 2	by Funeral	1 Never Merried 28 Ma 3 Widowed 4 Divorce	rried 1 ☐ Yes	orces? 2 1 No ive		If Yes, spec	ify Cub	Specify	n, Puerto	Rican, etc.)		ck, While,	etc.
15-002 72 hours	ted	15. Decede	nt's Education est grade completed)		16a. Dece	dent's Usua	I Occup	ation	et of worki	ina	16b. Kind of B	usiness/in	dustry
· ·	Be Completed	Elementary/Secondary (0-12)	College (	(1-4or 5+)	life.	kind of wor DO NOT us	e retire	d)	or work	· · · ·			
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, Mar and 2 sho belth and 127 is m		19a. Informant's Name/Relation Son M. Nguye		r-in-Law						Potoma			
Baltimore, emit. Peges 1 ar epartment of Hee my Injury or other		20a. Method of Disposition	2 Demonstrati	00	ace of Disponentery, cre	osition (Nan	ne of ther ple	ce)		Date	20c. Location	City or To	own, Stale
Peg nent: H		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (		Nor	thern	Virgi	inia	Crem	ator	y11/3/0	O Arlin	gton,	Va.
mit.	ouce.	21. Signature of Funeral Service	Licensee		2:	2. Name an	d Addre	ss of Facil	ity Ar	lington	Funera	1 Hor	10
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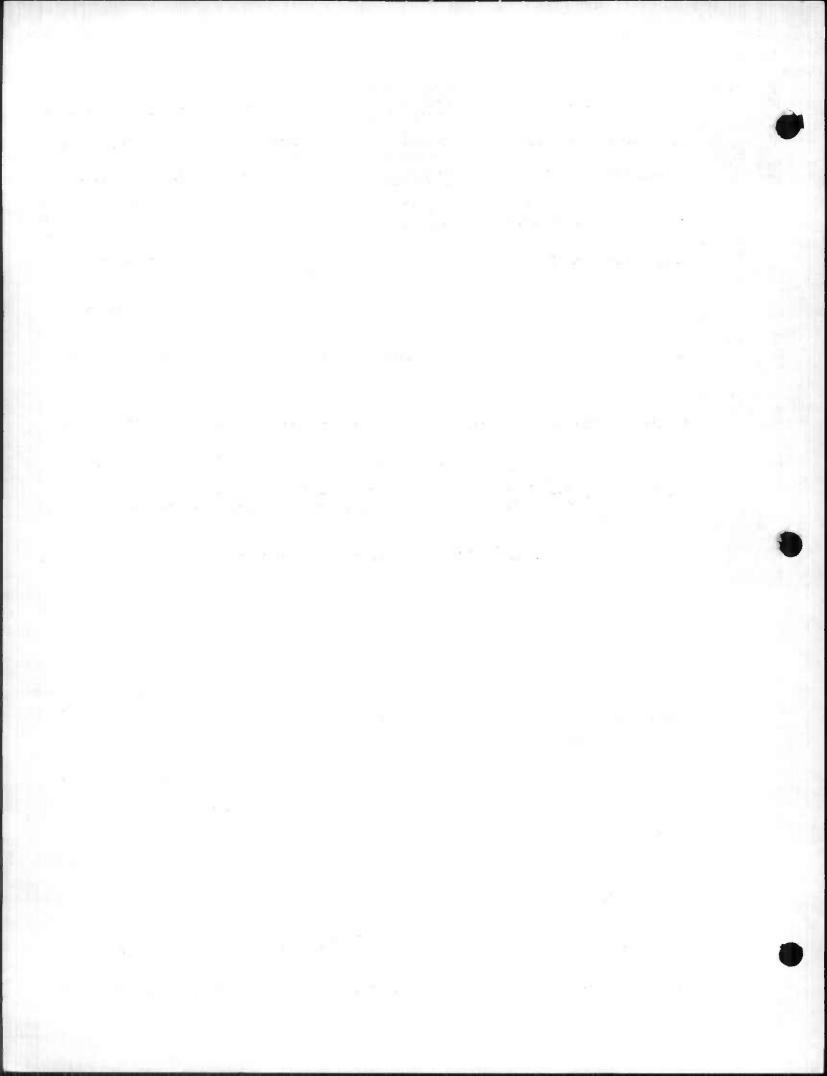
State of Maryland / Department of Health and Mental Hygiene

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irector: After this certificate has been signed by the attending physician and the property of the funeral director, page 2 should be detached for use as the burial-transit of 100 miles.	Be Completed by Physician/Medical	Immediate Causa disease or condition rasulting in death a sulting in death in the causa. Enter Und Causa Enter Und Causa Enter Und Causa (Disease of the initiated evan resulting in death)  Pert II. Other algn  25. Wes case rafe exeminar?  1 Yes 2  27. Manner of Dee 1 Maturel 2 Accident 3 Sulcide	onditions, mediata lertying or Injury to Lest  If I cant conditions of the condition	a. ME  b  c  d  ME ALL TU  Hospital:  19 gation  not be 28e. F.  19 gation  10 gatio	to death bu	Due to (or e	Do not entered as a consequence of c	2 Souter the mode  OSTA  quance of):  uence of):  uence of):  definition of the second	A Other	econd S g, such es card  CAN (  CAN (  26. Plece of D  17: 4    Nursing  18: 2    No  19: 4    Nursing	eeth (Cheeth Cheeth Che	Be De I retory error  3b. Did to  1  Ye  4a. Wes er perform  1  Ye  4c. A only on.  A reside asscribe ho  cation (Stay or Town  e to tha cae	bacco use cos 2 Noned?  Noned?  No N	ontribute 3 Pr  24b. \ \text{ther (Spectarred)}	Approximate Interval Between Onset end Deeth Service 1 Conset end Deeth Ser
interfact Arter this certificate has been signed by the attending physician and in p. p. or in by the funeral director, page 2 should be detached for use as the burial-transit and in b. or in the funeral director, page 2 should be detached for use as the burial-transit and in b. or in the funeral director, page 2 should be detached for use as the burial-transit and in the funeral director, page 2 should be detached for use as the burial-transit and in the funeral director, beginning the funeral director.	Certification: To Be Completed by Physician/Medical	Immediete Ceusa disease or conditi rasulting in death)  Sequentially list or if eny, leading to 1 causa. Enter Und Ceuse (Disease or thet initieted evan resulting in deeth)  Pert II. Other sign  25. Wes case rafe exeminar?  1 Yes 2  27. Manner of Deet 1 Naturel 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)	onditions, mediata lertying in Injury ts Lest  If Cant conditions invasting to medical	a. ME  b  c  d  Post contributing  AR  Hospital:  28e. E.  gation not be lined  28e. F.  gation on to be lined  28e. F.  gation on to be lined  28e. F.  gation on the line	to death bu	Due to (or e	Do not entered as a consequence of c	2 Souter the mode  OSTA- quance of):  uence of):  uence of):  anderlying ca  SE  M  A  Occurred e  vestigetion,  29c.	A Othai  A Othai  A Office  State of dying	26. Plece of Dr. 4 Nursing et ? (as 2 No	eeth (Cheeth Cheeth Che	Bb. Did to  1 Yes  A salide ascribe ho  cation (Stry or Town  e to tha case time, de	bacco use cos 2 Noned?  Noned?  No N	ontribute 3 Pr  24b. \ \frac{1}{2} \text{definition} \text{ther (Special red)} \text{menner es} \text{definition} \text{definition}	Intervel Between Onset end Deeth  5 YEARS  Ito the cause of dea robably 4 Vinking aveilable prior to completion of causa of deeth?  I Yas 2 No cify)  Iral Route Number, It to the cause(s)
After this certificate has been signed by the attending physician and up of property funeral director, page 2 should be detached for usa as the burial-transit up of up	edical Certification: To Be Completed by Physician/Medical	Immediete Ceusa disease or conditi rasulting in death)  Sequentially list or if eny, leading to causa. Enter Unic causa. Enter Unic causa the control of the initiated evan resulting in death)  Pert II. Other sign  DIABEC	onditions, mediata lertying in Injury ts Lest  If Cant conditions invasting to medical	a. ME  b  c  d  Post contributing  AR  Hospital:  28e. E.  gation not be lined  28e. F.  gation on to be lined  28e. F.  gation on to be lined  28e. F.  gation on the line	to death bu	Due to (or e	Do not entered as a consequence of c	2 Souter the mode  OSTA- quance of):  uence of):  uence of):  anderlying ca  SE  M  A  Occurred e  vestigetion,  29c.	A Othai  A Othai  A Office  State of dying	26. Plece of D.  (1) 4 Nursing et ?  (2) 4 No. (2) No. (3) No. (4) No. (4) No. (5) No. (5) No. (6) No.	eeth (Cheeth Cheeth Che	Bb. Did to  1 Yes  A salide ascribe ho  cation (Stry or Town  e to tha case time, de	bacco use comes 2 No neutopsymed?  ses 2 No neutopsymed?  ses 2 No nece 6 O O O O O O O O O O O O O O O O O O	ontribute 3 Pr 24b. 1	Approximate Interval Between Onset and Deeth 5 YEARS  It to the cause of dea robebly 4 Winkin Were autopsy finding aveilable prior to completion of causa of deeth?  I Yas 2 No city)  I aral Route Number, is steted. It to the cause(s)

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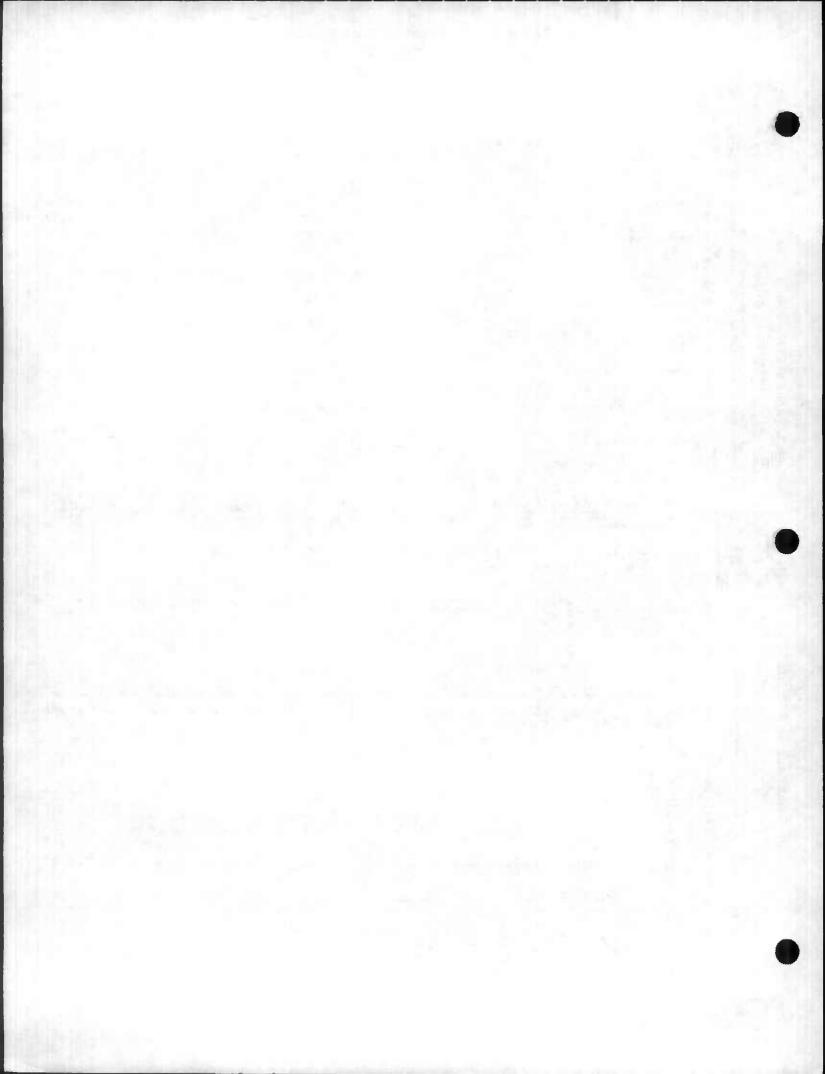
Registrar



State of Maryland / Department of Health and Mental Hygiene 00 37451

			Certificate of Death	Reg. No.	00 01401
	Physician	1. Decedent's Nama (First, Middla, Last)		2. Date of Death Month Day	3. Time of Death
1	/Medical	Howard Elton Turner			2000 2349
	Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or L		ounty of Death
ш		The Memorial Hospital  5. Social Security Number 6. Sex 7. Aga (In yrs. las	East		Talbot
	Funeral Director	281 - 26 - 1333 1 1 M M 2 ☐ F 81  Usual Rasidence of Decedant	Yrs. Months Days Hours Min.	8. Data of Birth (Month, Day, Year) Sept. 1519	9. Birthplaca (Stata or Foreign Country) 19 Maryland
	Maryland H ahow fad at		Fown or Location Denton		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	fler deeth with the Maryland r flams 23s or 28s-f show the four barrottised at Funeral Director	10e. Street and Number 420 Colonial Drive	10f. Zip Code 21629		ted States
020	at, or its	11. Marital Status  1 Navar Married 2 Married  3 Widowed 4 Divorced  12. Was Decedant Ever in U,S. Armed Forces?  1 Navar Married 2 Narried If Yas, Give Year or Dates: 4 2 – 4	13. Was Decedent of Hispenic Origin? (Silf Yas, specify Cuban, Mexican, Puerto	o Rican, etc.)	Race - American Indian, Black, Whita, atc.
Oward Turner Maryland 21215-0020	be filed within 72 ho tal Hygiene. d other than "natura event, the Medical Be Completed	15. Decedent's Education (Specify only highast grada complated)  Elementary/Secondary (0-12)  Collega (1-4or 5+)	16a. Decedant's Usual Occupation (Giva kind of work dona during most of wor lifa. DO NOT usa ratired)  Do a document of work dona during most of wor lifa. Do NOT usa ratired)	king	of Businass/Industry
1 5 E	Hygier the out, the Cor	10th	Painter	na (First, Middla, Maidan Su	
dance	id be fi ental F ked out c ave	17. Father's Nama (First, Middla, Last) George Wrightson Turner		Jane Moore	
ar	should Ind Menion I market		19b. Mailing Addrass (Street and Number or Ru		
Howa e, Mary	and 2 saith ar n 27 is	Jane E. Tull/ Sister	4311 Laurel Grove	RD.Federal	sburg, MD
ıe, ≖	of Hear Mem other	Cem	e of Disposition (Nama of atary, crematory or other place)	Data 20c. Loca	tion - City or Town, Stata
Ē	Peges nent of int: If its ury or o		Veterans Cemetery	11/8 Hurl	ock, Maryland
H. Baltimore,	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than eny injury or other traumatic avent, the Magnes.  To Be Compl	21. Signature of Funaral Sarvice Licensee  Musture M. Walle	22. Nama and Addrass of Facility Framptom-Hawkin 216 N. Main St.	s-Eskow Fur	neral Home
		23a. Part1. Enter the diseasa, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not antar tha moda of dying, such as cerdiac	or raspiratory arrast,	Approximata Intervel Between
0	Physician /Medical Examiner	Immediata Causa (Final disaasa or condition	NARY EMBO		Onset and Daath
	1,73	resulting in death)  Due to (or e	s e consequence of):		
7678	nsit T	b			
ć	trificate be executed g physician and as the burial-transit	Sequantially list conditions, if any, laeding to immedieta ceuse. Enter Undertying Cause (Disease or Injury	s a consequence of):		
68760,	death certificate be attending physicia of for use as the burst lician/Medical	that initiated evants	s a consequence of):		
	2 5 5	rasulting in death) Last			
Вох	attending for use a	d			
	the at hed for hed for	Part II. Other significant conditions contributing to death but not resulting	ng in tha undarfying causa givan in Part I.	23b. Did tobacco us	s contribute to the cause of death?
s, P.(	iras that the death cei signed by the attendir d be detached for use d by Physician/A	Failure to thrive		1 Yes 2	No 3 Probably 4 Unknown
cord	v requirements	Peripheral Vascular	disease	24e. Was an autopsy performed?	24b. Were autopsy findings availabla prior to complation of cause of death?
Œ.	yeicien: The lev is certificate hes director, page 2	GI bleed.		1 ☐ Yes 2 🔀	No 1 Yes 2 No
ita	entifica actor, Be C	25. Was cesa referred to medical axaminar?	26. Plece of Dec	eth (Check only one)	
2	Physician: rthis certificated director, r: To Be (	1 ☐ Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ EF		lome 5 ☐ Rasidence 6 [	
no	Ing P Wher t where where	1) Natural 5 Panding (Month, Day Year)	Bb. Tima of Injury at Work?  M 1 Yas 2 No	28d. Dascribe how injury of	occurred
Division of Vital Records, P.O	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director and	2 Accident invastigation 3 Suicide 6 Could not be detarmined detarmined  28e. Place of Injury - At home building, etc. (Specify)		28f. Location (Street and I City or Town, Stafa)	Number or Rural Routa Number,
	ne Hospita n 24 hours ne Funera pletely fille edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle and mannar stated.	dga, daath occurred at the time, dete end plece n and/or invastigation, in my opinion, daath occu	o, and dua to the cause(s) are	nd menner as stated. lace, and dua to tha ceuse(s)
	Withle To the comp	29b. Signatura and title of certifier	29c. License number		signed (Month, Day, Year)
		1 My Went 1	(D) D3528	54 /	1/02/00
		30. Nama and addrass of person who complated ceuse of death (Itam 2			
		Dr. Andrea Allen 219 S. Wa		Easton, MD	21601
	State	31. Data filed (Month, Day, Year)  32. Registrar's Signatur	19 board		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 37452

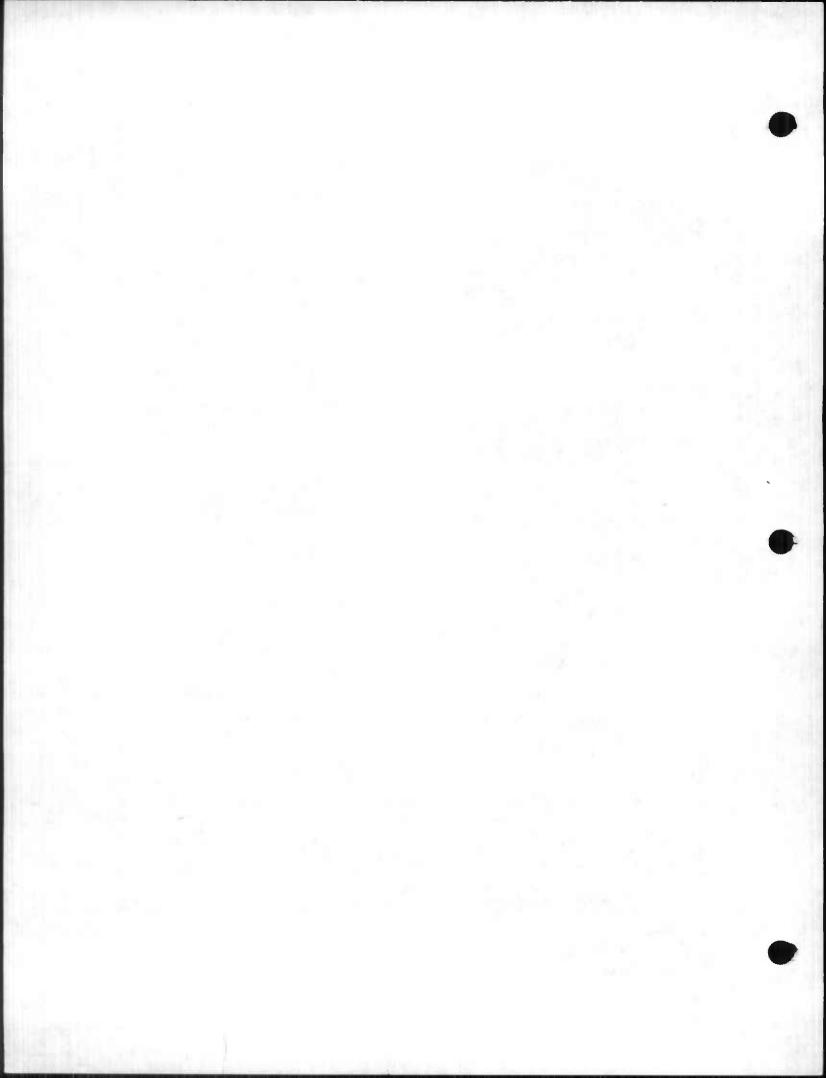
			Cen	tificate of	Death		Reg. No.		
Division	1. Decedent's Neme (First, Middla, Last					2. Date of Dea	ath Day	Yeer	3. Time of Death
Physician /Medical	WILBERT OLIN T	HOMAS, SR.					_	2000	2155
Examiner	4a Fecility Nema (If not institution, give	street and number)			4b. City, Town, or Lo	cation of Death	4c. County	of Death	
	The Memorial	Hospital			Easton		Tall	bot	
Funeral	5. Social Security Number 6. Sec	7. Age (In yrs.		If Undar 1 Yaer Months Deys	If Under 24 Hrs. Hours Min.	8. Deta of Birt (Month, Da	h v. Year)	9. Birthple	ece (State or Foreign
Director	Usual Rasidance of Decedant	]M 20F	77 Yrs.	lilonina Doys	riours isimi,	Dec.23	,1922	Mary	1and
Aland Aland	10a. Stata 10b. County	10c. Cř	ity, Town or Loc	ation				10	d. Inside City Limits
with the Marytar a or 28a-f show be notified at Director	MD Carol	ine		In The Code	Prest		10a China al l	Affron County	1 ☐ Yas 2 ☒ No
23a or 2 Mart be or real Dir	23177 Hog Cree	k Road			21655		United	d Sta	tes
5-0020 72 hours after death v netural; or items 23s fical Examiner mant sted by Funeral	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Dacedent Ever in U Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:	If	/as Dacedant of H Yes, specify Cuba ☐ Yas 2 1 No	tispenic Origin? (Spe an, Mexican, Puarto Specify:	ecify Yes or No Rican, atc.)		a - Amarica ck, Whita, et :: Wh	
72 h	15. Decedent's Edu (Specify only highast grad	cation a complated)	16a. Decede	ent's Usual Occup	eation during most of worki	ing	16b. Kind of B		
1 21215-0020 sed within 72 hours at typiene, wer than "natural", or nt, the Medical Exam Completed by I	Elementary/Secondary (0-12)	College (1-4or 5+)	lifa. D	O NOT usa retire	ultry Fa		Agricu	lltur Poul	
D BEER O	17. Fathar's Nema (First, Middle, Last)				18. Mothar's Neme	(First, Middla,	Maiden Suman		
Marked of Mental marked of marked or marked or To B	Olin Thomas				Blanche	Schul	tz		
Story of the story	19a. Informant's Name/Reletionship (Ty	pe, Print)	19b. Meiling	Addrass (Straat	and Number or Rura	I Route Numbe	er, City or Town,	Stata, Zip (	Code)
	Violet M. Thoma	s/Spouse	2317	7 Hog (	Creek Rd	., Pre	ston,	MD 2	1655
of Table	20a. Mathod of Disposition		Place of Dispos			Data	20c. Location -		
Sattimore, semit. Pages 1 at Separtment of Heal montants if Nem; my Injury or othe RES.	1 🕅 Burial 2 🗆 Cremetion 3 🗆 F 4 🗆 Donation 5 🗆 Othar (Specify)	amoval from Stata	unior	Order (	Cem.	11/9			aryland
Departing any it	21. Signature of Funarel Service Licens	skw	Fr PO	amptom- Box 4:	ss of Facility - Hawkins B, Feder	- Eskow alsbur	Funer g, MD	al H 2163	ome, PA
ertificate be executed fing physician and se as the burial-trensit	Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaase or injury that initieted events resulting in death) Last	)	or as a consequence or a consequen	uenca of): uanca of):	THILYRE		1		12 HOURS
BOX 6 eath certification attending of the use estimated or color o								1	
d by the adetached for	Part II. Other eignificant conditions con	,	_	darlying causa giv	an in Part I.			ntribute to	the cause of death?
Attending Physician: The law requires that the death or redestly that the control of the control	CEREBRAL DIABETES M	ELLITUS					an autopsy med?	con	re autopsy findings ilable prior to apletion of causa eath?
The I he he he he he						10	ras 2 No	10	Yas 2 No
ulcien: The lav certificate hes rector, page 2	25. Wes casa rafarred to medical	W. Salara A.			26. Placa of Deatl	n (Check only o	one)		
s cer direc	axaminer? 1 ☐ Yes 2 No	lospital: Impatiant 2	ER/Outpatient	3□ DOA Oth				ar (Specify	)
	27. Manner of Death 1 Matural 5 Pending 2 Accidant Invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injui Wo M 1	ry et rk? Yas 2 □ No	28d. Dascribe	now injury occur	red	
of Attending a sher death.  I Director: After d in by the fune fune fertification	3 ☐ Suicida 6 ☐ Could not be determined	28e. Plece of Injury - At h building, atc. (Speci	nome, farm, stra	at, fectory, office		28f. Location ( City or To	Street and Numb vn, State)	ber or Rural	Routa Number,
To the Nooptal or Attending Physician: The laveling a function of the things of the function o		sician: To the best of my kno ner: On the basis of examina and mannar stated.							
To the To the Coomp	29b. Signature and title of certifier	5.		29c. Licans			29d. Data signa	d (Month, E	Day, Year)
	70	312		200	53815		11/0	6/2	000
	I Hama and addrass of person who co	implated causa of daath (Itar	m 23a) (Typa. F	Print)					2 1 2 2 1
State	Korah Pulimood 31. Deta filed (Month, Day, Year)		S. 5t		Denton	,MD 21	629		

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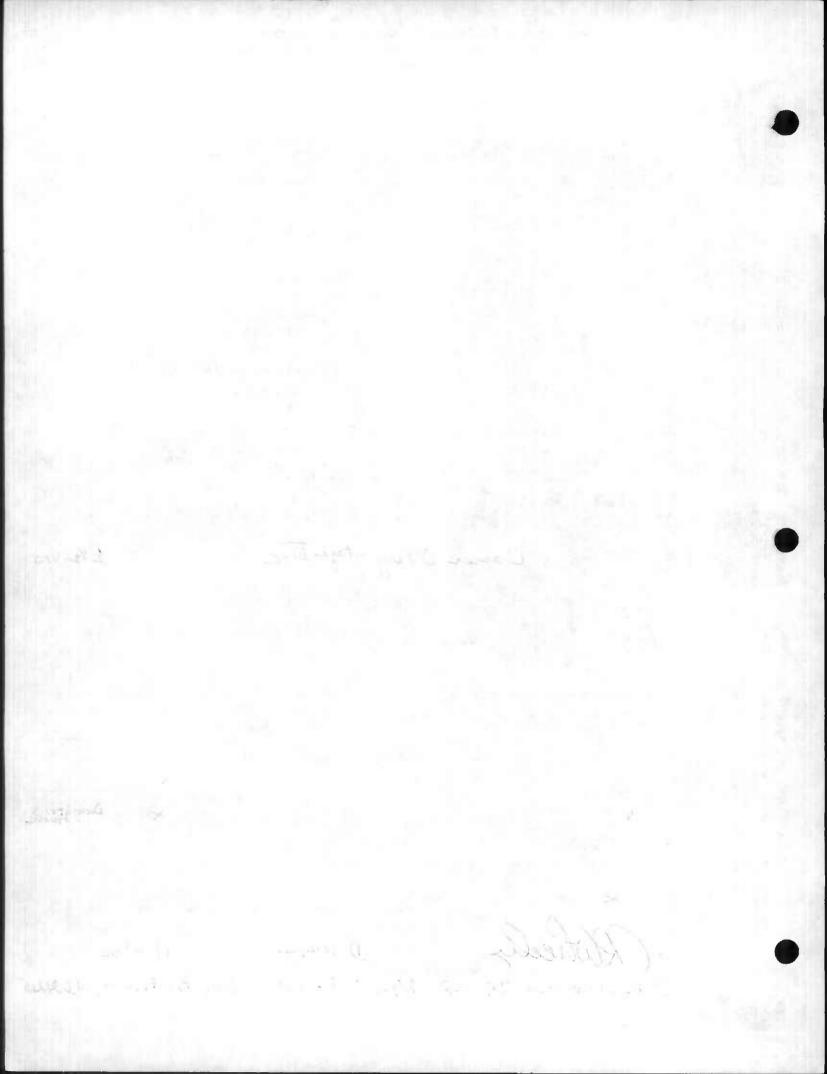
Registrar

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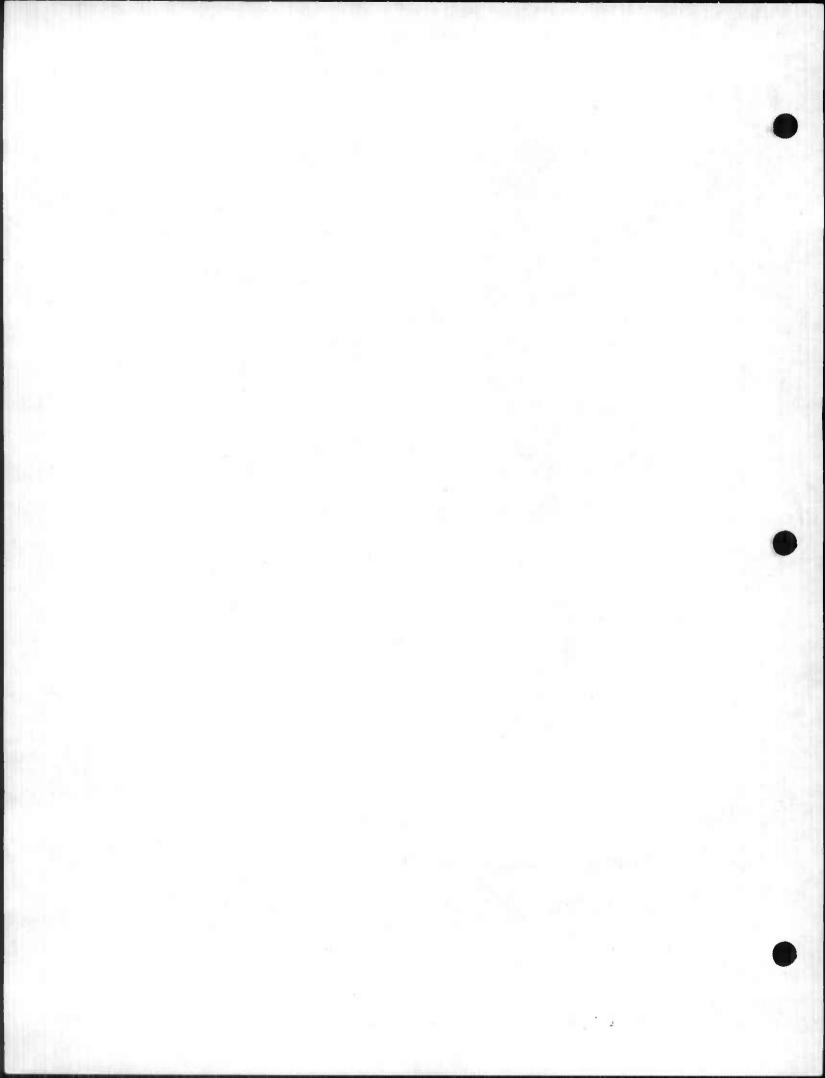
State of Maryland / Department of Health and Mental Hygiene 00 37453

				Cer	tificate of	Death		Reg. No.	0 0 7 7 0 0
	B) 1.1.	1. Decedent's Nama (First, Middla, Las	•		11.79.76		2. Data of Do	eath Day	3. Tima of Death
er.	Physician /Medical		Elizabeth	J. T	hompsor	)	NOV.	11, 20	
5	Examiner	4a Facility Nama (If not Institution, give			N'ER	4b. City, Town, or L			
		311 W. Centra			If Under 1 Year	Federal If Undar 24 Hrs.	9		oline
	Funeral Director	221-10-19/4	7. Aga (In yrs.	72 Yrs.	Months Days		(Month, D	ey, Year)	9. Birthplaca (Stata or Foraign Country) 8 Maryland
	P	Usual Rasidence of Decedent  10a. Stata 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	or 28s-f sho be notified at Director	MD Worche			F	ocomoke			1 □ Yas 2 □ No
200	zas or z wat be n	1508 Linden D			1	851			d States
21215-0020	ours after on rail, or items Example: n	11. Marital Status  1 □ Nevar Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedant Evar in U Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:		Vas Decedent of I I Yas, specify Cub I □ Yas 2\□\No	Hispanic Origin? (Span, Maxican, Puart	pecify Yas or N o Rican, atc.)	Specify	a - Amarican Indian, k, Whita, atc. :: White
5-0	natural dical	15. Decedant's Ed (Specify only highast gree		(Giva	lant's Usual Occu kind of work dona	during most of work	king	16b. Kind of Bu	sinass/Industry
121	yglore.  ver than "nature,  t, the Medical  Completed	Etamentary/Secondery (0-12)	College (1-4or 5+)	lifa. I	oo NOT usa ratire emaker	ed)		Own	Home
	Co April	17. Fathar's Nema (First, Middla, Last)		110111	CIII a K C I	18 Mother's Nan	na (First Middle	a, Meidan Surnem	
Maryland	Be ever	Leslie Frankl	in Jones			14	J. Da		w/
2	Marries Marries Marries To	19a. Informant's Name/Reletionship (7		19h Mailin	n Address (Stree	t and Number or Ru			Stata. Zip Coda)
Ma	III and III an	Joshua M. Thom							
e,	S S S S S S S S S S S S S S S S S S S	20a. Mathod of Disposition	20b. I	Place of Dispo	sition (Nama of natory or other pla		Data	20c. Location -	City or Town, Stata
altimore	rimant or riant: If I njury or	Murial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	P i	tts C		. Cem.	11/15	Pocomol	ke, Maryland
Ba	Depart Ingo	21. Signature of Funeral Service Licen-	iskow	F	ramptom O Box 4	-Hawkin	s-Esko	w Funei	ral Home, PA 21632
e l		23a. Part1. Enter tha diseasa, or comp shock, or heart failura. List only	lications that caused the dea	th. Do not anti	ar tha moda of dy	ing, such as cardiac	or raspiratory	arrast,	Interval Batween
	hysician								Onsat end Death
	/Medical   Examiner	Immediata Causa (Final disaasa or condition resulting in death)	a. Cancer Dua to (	Ova	ry Stag	e III c			21/2 yrs
	THE PARTY NAMED IN	rooding in county	Dua to (	or as a conseq	uence of):				
	min nsk		b						
-	physician and sthe bundl-fransit	Sequentially list conditions, if any, laeding to immediata ceusa. Entar Underlying Cause (Disease or injury that initiated events	Dua to (	or as a conseq	uance of);				
68760,	E GE 8	Cause (Disease or injury that initiated events	C. Dua to (c	or as a consaq	uance of):				
68	- 00 -	rasulting in death) Last	Dua to to	n as a consaq	danos org.				-46
	use use		d						1 100
	to the deam cert d by the ettendin letached for use Physician/W	Part II. Other significant conditions co	intributing to death but not res	sulting in tha ur	ndarlying ceusa gi	iven in Part I.	23b. Dic	tobacco usa cor	ntribute to the cause of death?
P.0	by the stacked the						10	Yss 2 No	3 Probably 4 Unknown
	d d								
Division of Vital Records,	been s should leted						24a. Wa	s an autopsy formed?	24b. Wara autopsy findings available prior to complation of causa of daath?
A.	certificate has rector, page 2						1□	Yas 2 XNo	1 ☐ Yes 2 ☐ No
ta	yaictan: mark is certificate ha director, page To Be Com	25. Wes casa relarred to medical examiner?				26. Piece of Dec	th (Check only	one)	
>	00	1 Yas 2 No	Hospital: 1 ☐ Inpatiant 2 ☐	ER/Outpatien	t 3 DOA	ther: 4 Nursing H	oma 5 Ras	sidence 6 A Oth	ar (Specify) aughter 5
	fer the result of the result o	27. Menner of Death  1 Natural 5 □ Pending	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury		ork?	28d. Dascribe	how injury occur	red
Sio	eeth. or: A the fu	2 Accident investigation 3 Suicide 6 Could not be				]Yas 2□No	201 1 1	10	B - 1 B - 1 M - 1 A
ivic	or An in by	4 Homicide determined	28a. Place of Injury - At h building, atc. (Speci		eet, factory, office		City or To	(Streat end Ivumb own, Stata)	er or Rural Routa Number,
	to the negative Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (	(Check only 2 Medical Exam	relcian: To the best of my kno iner: On the basis of axamina						
	thin 2 mple	29b. Signature app title of Cauthier	and mannar stated.	-	29c Licen	sa number		29d Data signer	d (Month, Day, Year)
	2 3 6 8	1/1/V	006.		7	14.111			
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		30. Nama and address of person who of R w heel	complated causa of death (Ital	m 23a) (Type, 24	Frint)	Be Wedow	· Aug	Rolt:	more, MD \$1215
	State	31. Data liled (Month, Day, Year)	32. Registrar's Sign	1 "	01 00 .	Je peach	- /100.	)	בוגוע ויין
	Registrar	NOV 1 6 20	no Benevi		done	43			
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State of Maryland / Department of Health and Mental Hygiene 00 37454

					Certifica	te of	Death			Reg. No.		
		1. Decedent's Nema (First, Middla, Las	t)	11/2-5					2. Data of De		Miles	3. Tima of Death
	Physician	Margaret Elizab	eth Uber						Month Novem	ber 4, 2	Yaar OOO	1:45 pm
	/Medical Examiner	4a Facility Nama (If not institution, giva	street and number)				4b. City, To	wn, or Lo	cation of Deat			2.7.0
	LAdimilei	6802 2nd Street					Rive	rdal	e	Pri	nce	George's
	Funeral	5. Social Security Number 6. Se		(In yrs. last birth		er 1 Yaar	If Undar		8. Data of Bir (Month, Da			placa (Stata or Foreign
	Director	577-01-6161	□ M 2ŽÍF	92 Y	s. Months	Days	Hours	Min.	Sept. 2	7, 1908	Wash	hington, DC
	70	Usual Rasidence of Decedent										
	W M	10a. Stata 10b. County		10c. City, Town	or Location						1	10d. Insida City Limits
	Ma Ma	Maryland Prince	George's	River	dale							1 ☐ Yas 2 📉 No
	or 28a-f show be notified at Director	10a. Street and Number			10f. Z	ip Coda				10g. Citizen of V	What Cour	ntry?
	E - A - D	6802 2nd Street				207	37			U.S.A		
	ther death with the Maryla r lasms 23s or 28s-f show siner must be notified at Funeral Director	11. Marital Status	12. Was Decedent E Armed Forcas?	var in U,S.	13. Was Dec	edant of H	lispanic Ori	gin? (Spe	ecify Yas or No Rican, atc.)	)- 14. Rac	a - Amaric	can Indian,
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	and	Tim Uber - Nepher	W				et, R	iver	dale, 1			
ore	I tof H	20a. Mathod of Disposition 1 □ Burial 2 🖾 Cramation 3 □ I	Removal from State	20b. Place of I cemetery.	Disposition (Na crematory or	ama of othar plac	ce)		Data	20c. Location -	City or To	own, Stata
E	Pag	4 Donation 5 Other (Specify,		Metro	olitar	n Cre	mator	y 11	/9/2000	Alexan	dria	, Virginia
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	Physician	shock, or haart failura. List only o	ona causa on aach iir	a.							1	Interval Between Onsal and Death
Mr.	/Medical	Immediata Causa (Final	Watasha	+1- C-1.	1	D 4	-1 0-					6 36 .1
0.0	Examiner	disaase or condition rasulting in death)		tic Colo			ai ca	ncer			1	6 Months
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o,	en ar rial-trial-tr	Sequentially list conditions, if any, laading to immadiate ceusa. Enter Underlying Causa (Disease or Injury										
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m .	at the death ce d by the attend etached for us Physician/	Part II. Other significant conditions co	ntributing to death bu	it not resulting in t	ha underlying	causa div	an in Pert	1.	23b. Did	tobacco uae co	ntribute t	to the cause of death?
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S, D	5 60	Dementia - Alzhe:	ımers									
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	h. Aftar funar funar	1 Natural 5 ☐ Pending	(Month, Day	Year) Inj	ury M	28c. Inju	rk? Yas 2□		200. 2007.00	non mjary cood.		
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≥	or A Dirac	4 Homicida datarmined	28a. Place of Inju- building, ato	. (Specify)	ii, Straat, racte	ory, omce			City or To	wn, Stata)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
_	Hospital or 24 hours after Funeral Dirit staly filled in Mical Cert	29a. Cartifier 1X Certifying Phy	reician: To the best of	f my knowledge	death coourse	d at the ti	me date es	nd place	and due to the	newee/s) and m	ADD 24 AC	etated
	he Hospi in 24 hou he Funer plataly fill edical		iner: On the basis of end menner sta	axamination and/								
	To the Hospital o within 24 hours at To the Funeral DI complately filled in	29b. Signature and titla of certifier	S. A. Mollilot Sta		2	9c. Licans	a number			29d. Data signe	d (Month.	, Day, Year)
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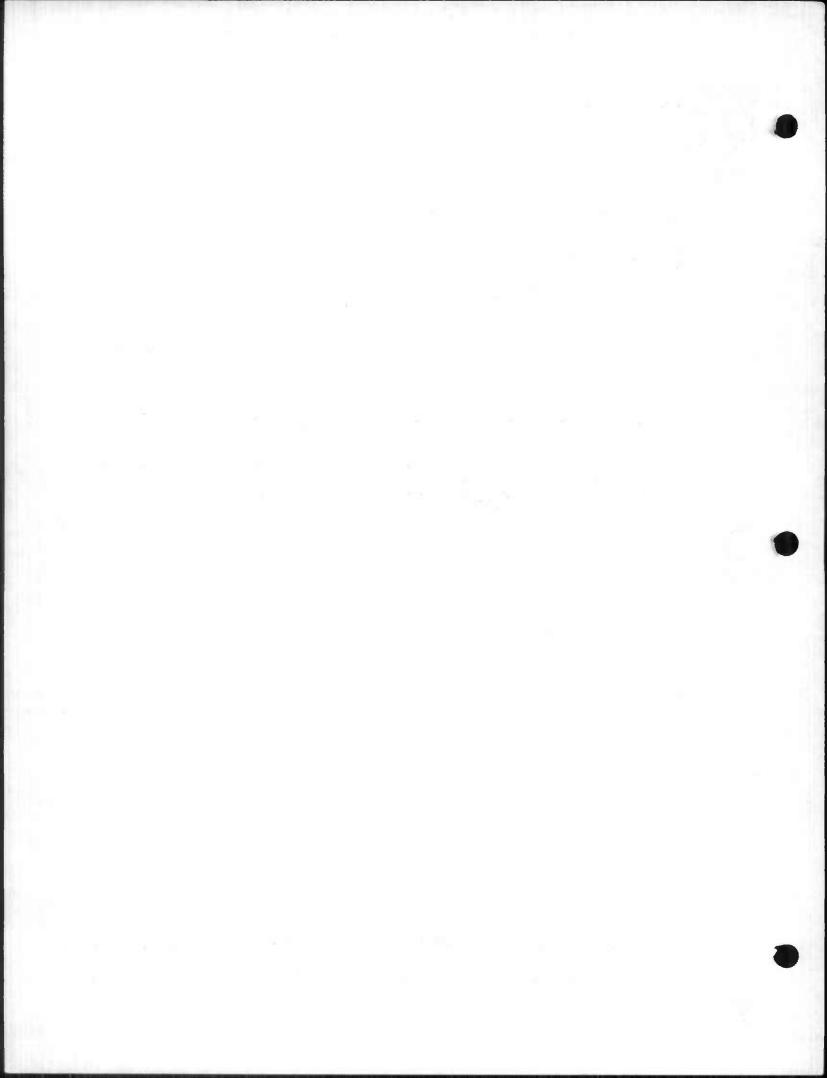
State of Maryland / Department of Health and Mental Hygiene  $\mathbb U$ 

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month 11 Gladys M. Utz 3:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Carroll Westminster Nursing Center Westminster 5. Sociel Security Number Birthplaca (State or Foreign Country)
 MD **Funeral** 1 M 2 F 213-05-3811 Director Usuei Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examiner must be notified at once. 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Umits Westminster MD Carroll 1 Yas 2 No Director 10e. Street end Number Run 10f. Zip Code 10g. Citizen of What Country? 21158 USA 119 W.Deep Road Funerai 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, atc. 11. Marital Status 1 ☐ Never Married 2 ☐ Merried Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: White p 3 Widowed 4 □ Divorced Completed Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Housewife. 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be G.Murray Erb Madeline Hesson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 119 W.Deep Run Rd. Westminster, MD 21158 Darlene Lyons -Daughter 20b. Pleca of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stata 4 □ Donetion 5 □ Other (Specify) 11/11/00 Silver Run, MD St.Mary's Cemetery 21. Signature of Eunerel Service Licana 22. Nama and Addrass of Facility Little's F.H. 34 Maple Ave.Littlestown, PA17340 tu 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Atheroscherofic Coronery Vascula Disent /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and s the burial-transit Sequentielly list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 1 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy findings evalleble prior to Completed 24a. Wes en eutopsy performed? completion of causa of death? certificata 1 Yas 2 No 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, i 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 A Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 10 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of Certification: 1 -Natural 5 Pending 1 ☐ Yes 2 ☐ No Invastigetion 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, streat, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number Poul 1. Mons, MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

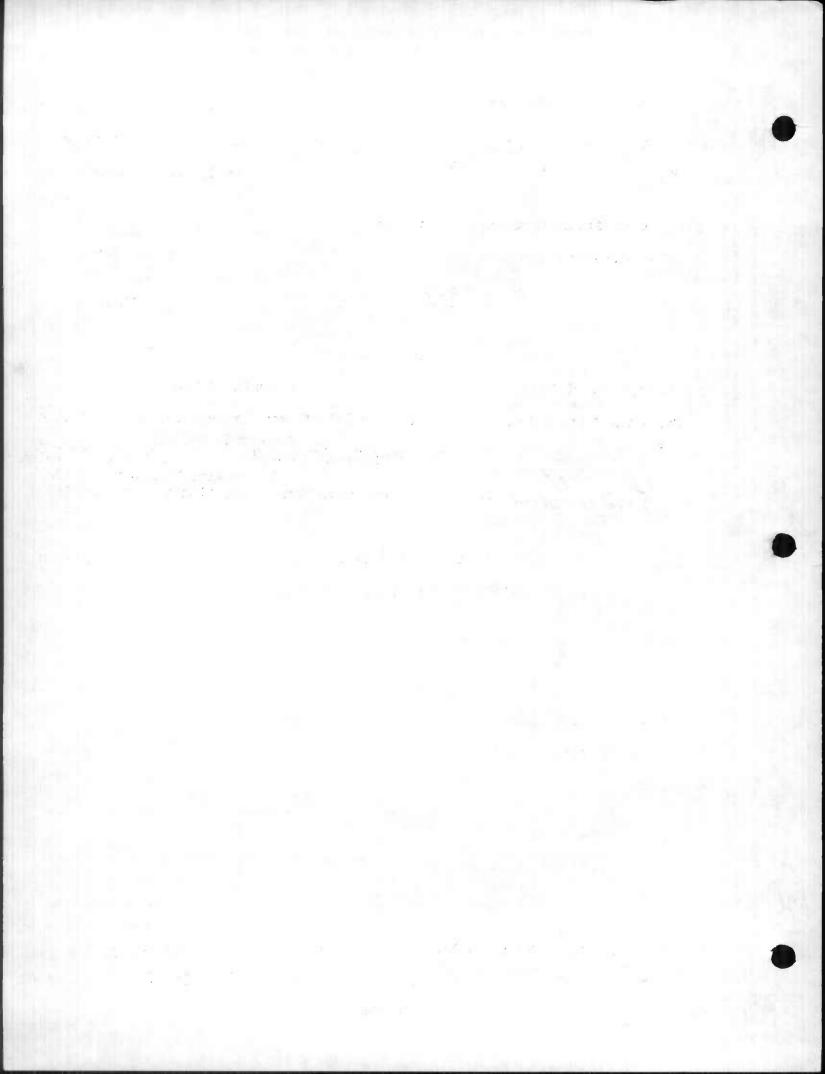
Robert C. Mars 1/4 Business Cont. Raister, Inc., Md 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Deneva NOV 0 9 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Yee Month **Physician** George William White NOVEMBER 02, 2000 08:03 P.M. /Medical 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGE'S If Undar 1 Yaar if Under 24 Hrs. Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Hours Deys 1⊠M 2□ F 83 Yrs. Director Boston, Mass 019 10 0099 Usual Residence of Deceden the Marylend 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County ie filed within 72 hours efter deeth with the Marylen al Hyglene.
Jother than *naturel', or items 23a or 28a-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Camp Springs Maryland Prince George's 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? United States 20748 7104 Kingston Drive Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No 1947-Specify. White 1 ☐ Yes 2 ☐ No X Baltimore, Maryland 21215-0020 Specify: þ 3 ₩idowed 4 Divorcad 1965 Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NASA 12 Communications 18. Mother's Name (First, Middle, Meiden Sumame) permit. Pages 1 and 2 should be flie Department of Health and Mantal Hy Important: If Itam 27 Is marked othe any lighry or other traumatic event BRGs. 17. Fether's Neme (First, Middle, Last) George Edward White Helen M. Cotter 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 27410 19a. Intormant's Neme/Relationship (Type, Print) 2008 Needleleaf Lane, Greensboro, North Carolina Dr. Randall White (SON) 20b. Plece of Disposition (Neme of November 7, 2000 Location - City of Town, State Clinton, Maryland 20e. Method of Disposition Lee Crematory Nov. 7, 2000 Maryland Veterans Cemetery 1 ☐ Burial XXX remetion 3 ☐ Removel trom State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility ee Funeral Home, Inc 6633 Old 21. Signature of unaral Service Voersee Alexandria Ferry Road, Clinton, Maryland 20735 aus voran Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical e. LETHAL CARDIAC ARRYTHMIA Examine UNKNOWN Due to (or es e consequence of) Examiner CORONARY HEART DISEASE certificata be executed physician and s the burial-trens Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury that initiated events rasulting in deeth) Lest Dua to (or as a consequenca of): Box 68760 Physician/Medical Due to (or es a consequence ot) 80 esn 10 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 2 MYOCARDIAL INFARCTION Records, þ 8 been si 24b. Were autopsy tindings eveileble prior to 24e. Wes en eutopsy performed? Completed CONGESTIVE HEART FAILURE completion of cause of deeth? page 2 has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No certificate Division of Vital 25. Wes case referred to medical exeminer? director Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 N ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending Investigation As Hospital or Atten-1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours To the Funeral I completaly filled 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as steted.

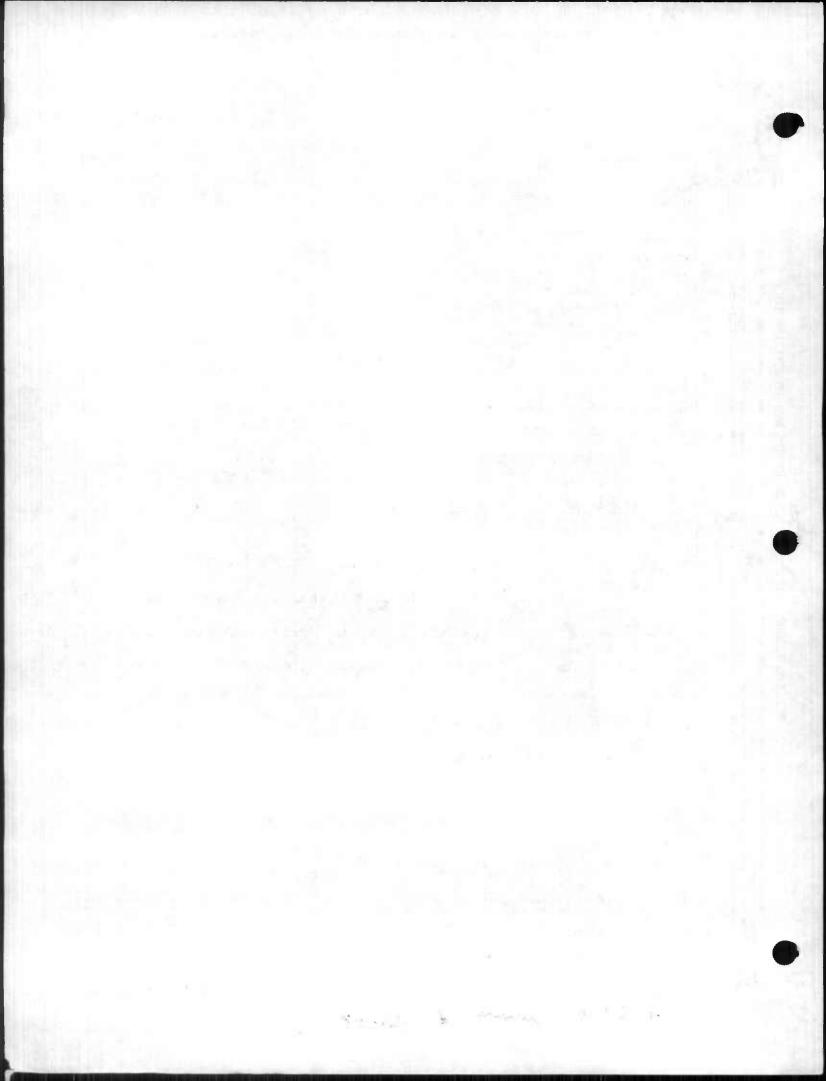
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to tha causa(s) end menner stated. 29e. Certifier edicai (Check only one) 29c. Licensa number 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifier Sarace 00, H0056438 NOVEMBER 02, 2000 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) 89 MDG/1050 W. PERIMETER ANDREWS AIR FORCE BASE, BRIAN S. SARACINO, CAPT, USAF, MC 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture State

Registra



State of Maryland / Department of Health and Mental Hygiene

Decided Name of the addition					Otate of Wi	arylana /		cate of	Death		Reg. No.	3	7457
## PROVIDED COUNTY OF THE PROVIDED COUNTY OF			1. Decedent's Name	(First, Middle, La.	st)								3. Time of Death
4. Statistic content plants and		•	F	RANCINE	WILLIAMS					111			11:08 Am
School Stockery Number   School Stockery Num			4a Facility Neme (If	not institution, giv	e street end number)				4b. City, Town, or I			of Death	
The control of the co			DOCTORS	COMMUNIT					LANHAM		PRINC	E GEO	RGES
The property of the property o	F	uneral	5. Social Security Nu			e (In yrs. last b	Mo			8. Dete of Birt (Month, Da	h y, Year)	9. Birthpled	e (Stete or Foreign
Top   Control	D	irector		81		56	115.			Nov. 1	1,1943	wasn.	р.с.
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11   Maria Status   12   Was Deposited Eve in U.S.   13   Was Deposited of Specify Vas on No.   14   Rasa-American Index,   15   Was Deposited in Specify Users,   Maria Completed   10   Was Cline   10   Was C	W. C	at bu	4103 Walke	erton Con	urt			20706		A. A.	U.S.A.		
The state of the s	dea	IT IT IT			12. Was Decedent	Ever in U,S.	13. Was I		lispanic Origin? (Span, Mexican, Puert	pecify Yes or No			
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The state of place of	0 4	Day 2			III	20b. Plece	of Disposition	(Name of				City or Town	n, State
22. Name and Address of Facility   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  201 Physician   Microscopian   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  202 Physician   Microscopian   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  203 Physician   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  204 Physician   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  205 Physician   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  206 Physician   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  207 Physician   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  208 Physician   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  208 Physician   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  208 Physician   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  208 Physician   Johnson & Jenkins Inc.  716 Kennedy St., N.W. Wash, D.C. 2001  208 Physician   Johnson & Jenkins Inc.  208 Physician   Johnson & Jenkins Inc.  208 Physician   Johnson & Jenkins Inc.  209 Physician   Johnson & Jenkins Inc.  200 Physician   Johnson & Jenkins Inc.  200 Physician   Johnson & Jenkins Inc.  201 Physician   Johnson & Jenkins Inc.  202 Physician   Johnson & Jenkins Inc.  203 Physician   Johnson & Jenkins Inc.  204 Physician   Johnson & Jenkins Inc.  205 Physician   Johnson & Jenkins Inc.  206 Physician   Johnson & Jenkins Inc.  207 Physician   Johnson & Jenkins Inc.  208 Physician   Johnson & Jenkins Inc.  208 Physician   Johnson & Jenkins Inc.  209 Physician   Johnson & Jenkins Inc.  200 Physi	non sega	8 2	1 Buriel 2	Cremation 3					1	1//00			
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Physician (Toledical Examiner)    Toledical Examiner   Toledical Examine			23a. Part1. Enter the	disease, or com	plications that caused	the death. Do	not enter the	mode of dyin	ng, such as cardied	or respiratory e	rrest,	. A	Approximate
Seaso or condition of eaching in death)  Season or conditions of each of the control of each of the control of each of												C	Inset and Death
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30b. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Dete (filed (Month, Day, Year))  32. Registrer's Signature  28f. Location (Street and Number or Rurel Route Number, Editory, office City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)  28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)	O L	2 -		5 Cl Dentine	28a. Date of Inju	ry 28b.	Time of						
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day Yes November 1,2000 **Physician** Edith P. Wooten 10:15 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) 8/16/35 7. Age (In yrs. last birthday) If Under 1 Yaar 5. Social Security Number Birthplece (State or Foreign Country) Funeral Months Days Min 1 □ M 2 🛛 F Hours 65 578-52-9668 Director Dillon, S.C. Usual Rasidence of Deceden 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Wedical Examinar must be notified at D.C. N/A Washington 1 TYas 2 No Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 3025 M Street, S.E. 20019 U.S.A. Funeral 12. Was Decedent Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, etc. 1 ☐ Yes 2 No If Yas, Give 1 Nevar Married 20 Merried 1 Yas 2√No Specify: Specify: Black by 3 Widowed 4 Divorced Yaar or Datas Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. iene. Elementery/Secondery (0-12) Collega (1-4or 5+) Social Worker D.C. Government YRS. 18. Mother's Nama (First, Middla, Maiden Surneme) 17. Fathar's Nema (First, Middla, Last) 2 should be fi Macile Galloway Ernest Floyd 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) permit. Pages 1 and 2 at Depertment of Health and Important: if Itam 27 Is in sny Injury or other traun once. 3025 M St., S.E., Wash., D.C. Willie G. Wooten/Husband 20019 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crametory or other place) Data 20c. Location - City or Town, Stete Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) 11/8/00 Washington, D.C. Glenwood Cem. 21. Signatura of Funaral Sarvice Licensee 22. Nama end Address of Facility H.S. Washington & Sons Co., Inc. Grail W. a 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata fnterval Between Onset and Death **Physician** SEPTICEMIA /Medical Immediata Causa (Final disaasa or conditi resulting in daath) Examiner Dua to (or as a consaquance of) LONEPHRITIS Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immadiata ceusa. Entar Undarfying Cause (Diseasa or injury that initieted avents rasulting in death) Last Due to (or es e consequence of) Physician/Medical Dua to (or as a consequanca of) Part II. Other afgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dfd tobacco use contribute to the cause of death? yd bengis 1 Yaa 2 No 3 Probably 4 Vunknown CERSBROVASCULAR ACCIDENT à 24b. Ware autopsy findings available prior to 24a. Was en autopsy performed? Completed DIABETES MELLITUS completion of cause of deeth? eral Director: After this certificate has filled in by the funeral director, page 2 1 ☐ Yes 2 No 1 ☐ Yas 2 No 25. Was casa rafarred to medicel examiner? Be 26. Placa of Death (Chack only ona) Hospital: 1 Inpatiant 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 10 1 Yas 2 No 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27 Mannar of Death 28b. Tima of 28c. Injury at Work? Certification: 5 Pending invastigation 1 Netural 1 TYas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 6 Could not be determined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) after a 4 Homicide Hospital of hours a To the Hospital within 24 hours a To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated. 2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, and dua to the cause(s) and mannar stated. 29e. Certifiar edical one)

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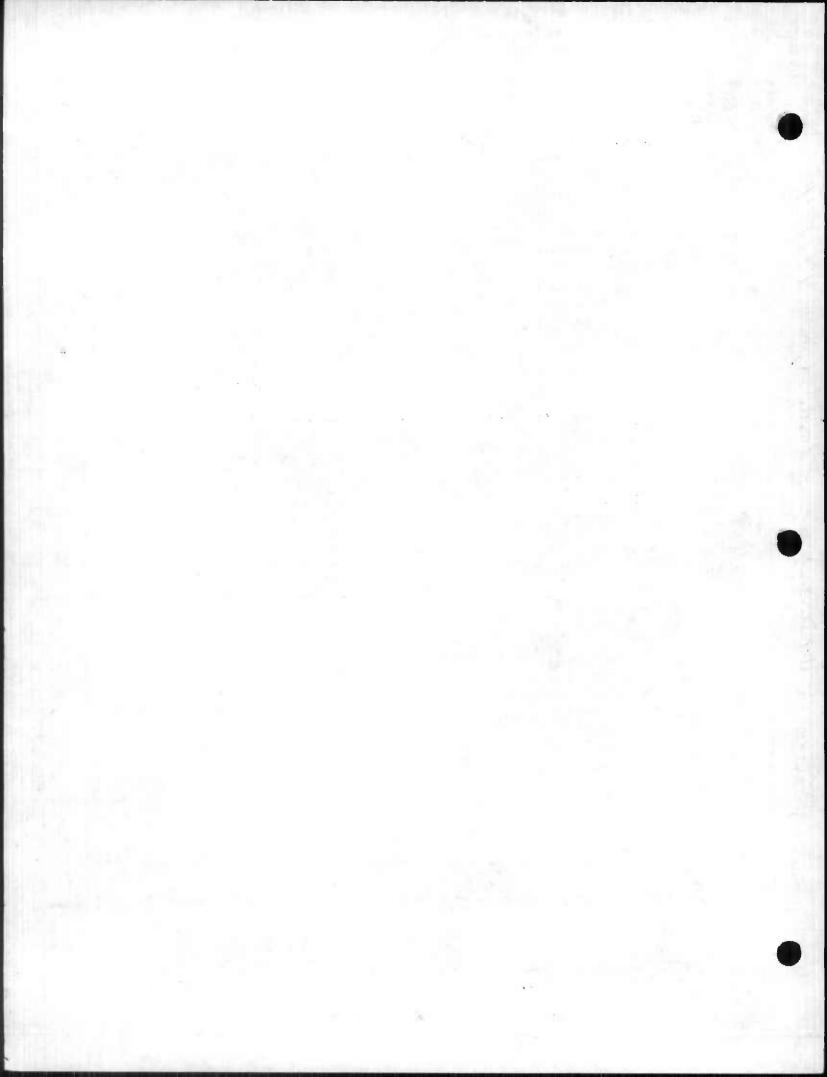
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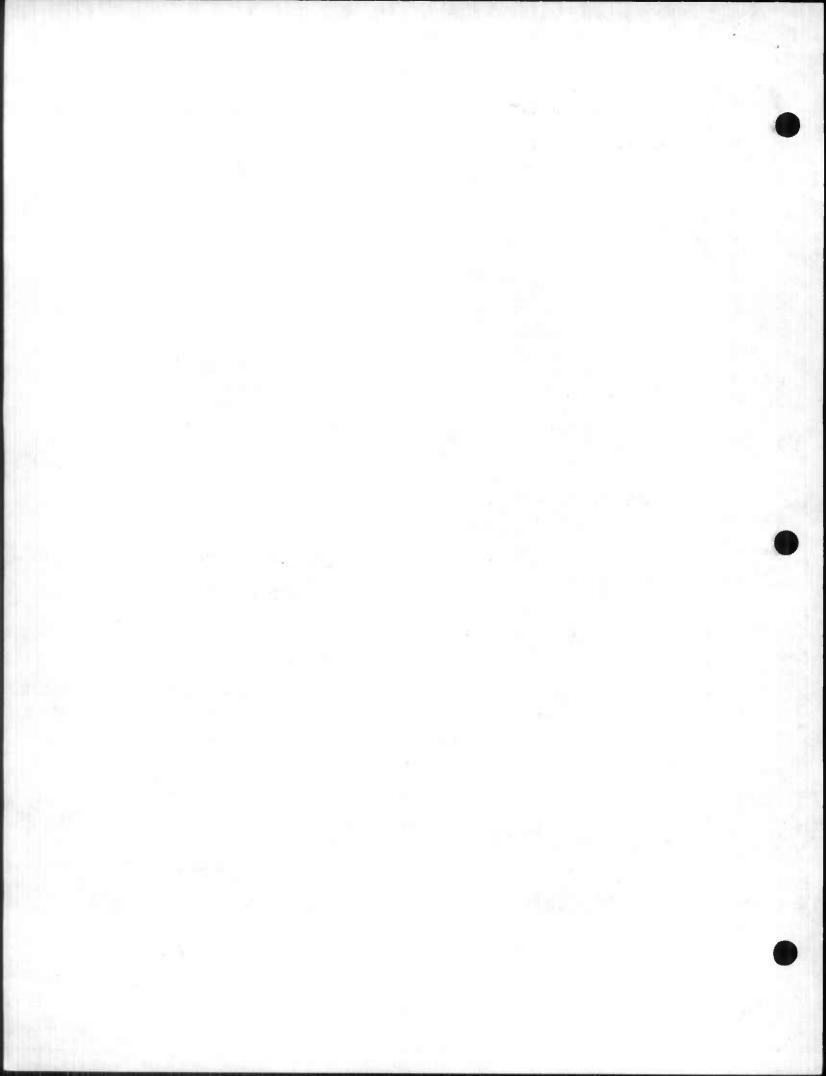
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37460 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Dorothy Louise WEAGLY 2000 NOV. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Boonsboro )ashington anrne Keed Home If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Numbar 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year, 9. Birthplace (State or Foreign Country)
Ohio **Funeral** Months Deys 1 □ M 2180 F 92 282-22-4882 Yrs Director Usuel Rasidance of Decedent 10e. State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Montgomery 1⊈ Yes 2 No Takoma Park 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 600 Ethan Allen Avenue 20912 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ≥ 2∑No
If Yes, Give
Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American indien, Bleck, White, etc. 1 X Never Married 2 ☐ Married white 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DD NDT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Pages 1 and 2 should be filled within nent of Health and Mental Hygiene. ant: If item 27 is marked other then 'ury or other traumatic event, the Ma Elamantary/Secondary (0-12) College (1-4or 5+) 0 - 12principal 4 elementary school 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middla, Maiden Sumema) Be John D. Weagly Gertrude Clark Hursey 19e. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Numbar or Rural Route Number, City or Town, Steta, Zip Code) Mrs. Jean Leonard Bushnell-niece 28 Mountain View Drive, Boonsboro, Maryland 21713 20b. Plece of Disposition (Name of cematary, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any injury or Nov. 12,2000 Hagerstown, Maryland Hagerstown Crematory 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funerel Servica Licensee 22. Name end Address of Fecility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 istal on Lil 2 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intarvai Betw Onset end Death **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last use as the buriel-trer Due to (or es e consequenca of): Physician/Medical Due to (or es e consequenca of): Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Quaknown ageneration þ 24b. Wara eutopsy findings evelleble prior to completion of cause of deeth? 24a. Was en eutopsy 1 Farler Deby deetien this certificate hes 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Deeth (Chack only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28c. injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Panding Investigation iniun To the Hospital or Attandin within 24 hours efter death. To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, lectory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data end place, and due to the ceusa(s) and menner as stated.

2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, data and place, end due to the cause(s) end menner steted. Medical (Check only one) 29b. Signeture end title of cartilier 29c. License number 29d. Date signed (Month, Day, Year)

State

Attanding F er death. After .

altimore, Maryland

the death certificate be executed

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P.O.

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31. Dete filed (Month, Day, Year)

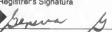
32. Registrer's Signatura

NOV 1 3 2000

VASANT DATTA, MO

- and Mo

30. Name end address of person who completed causa of death (item 23a) (Type, Print)



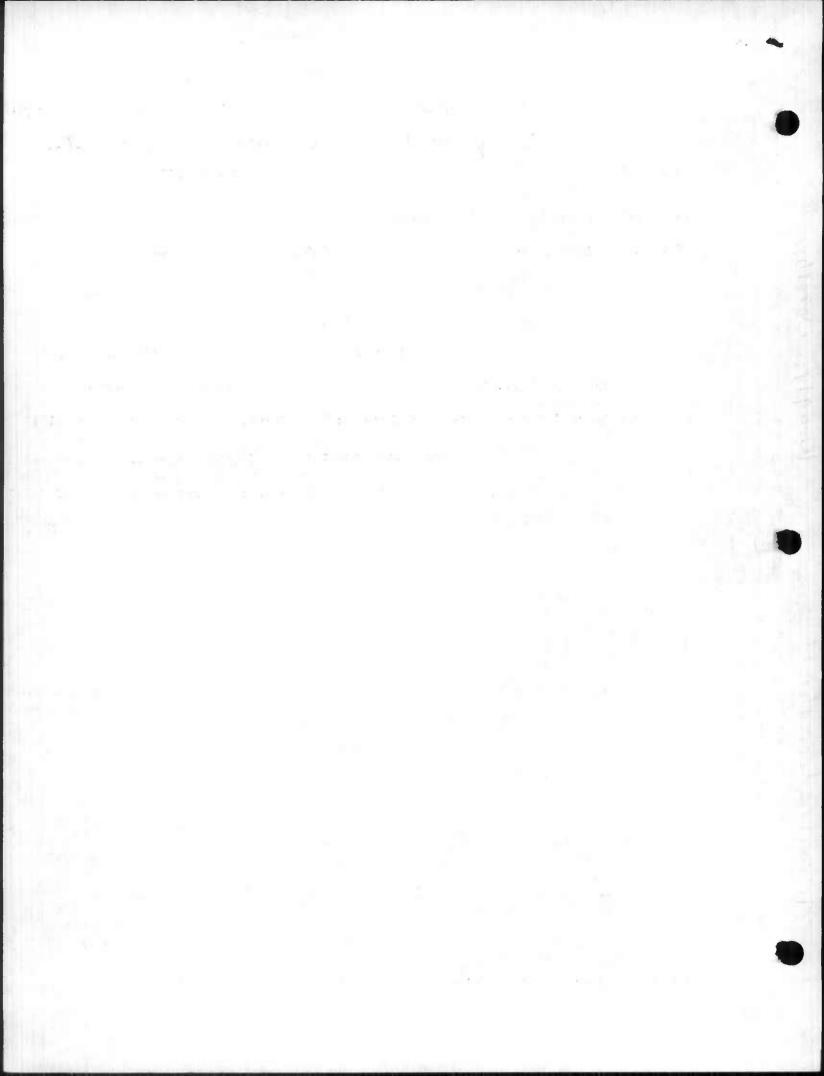
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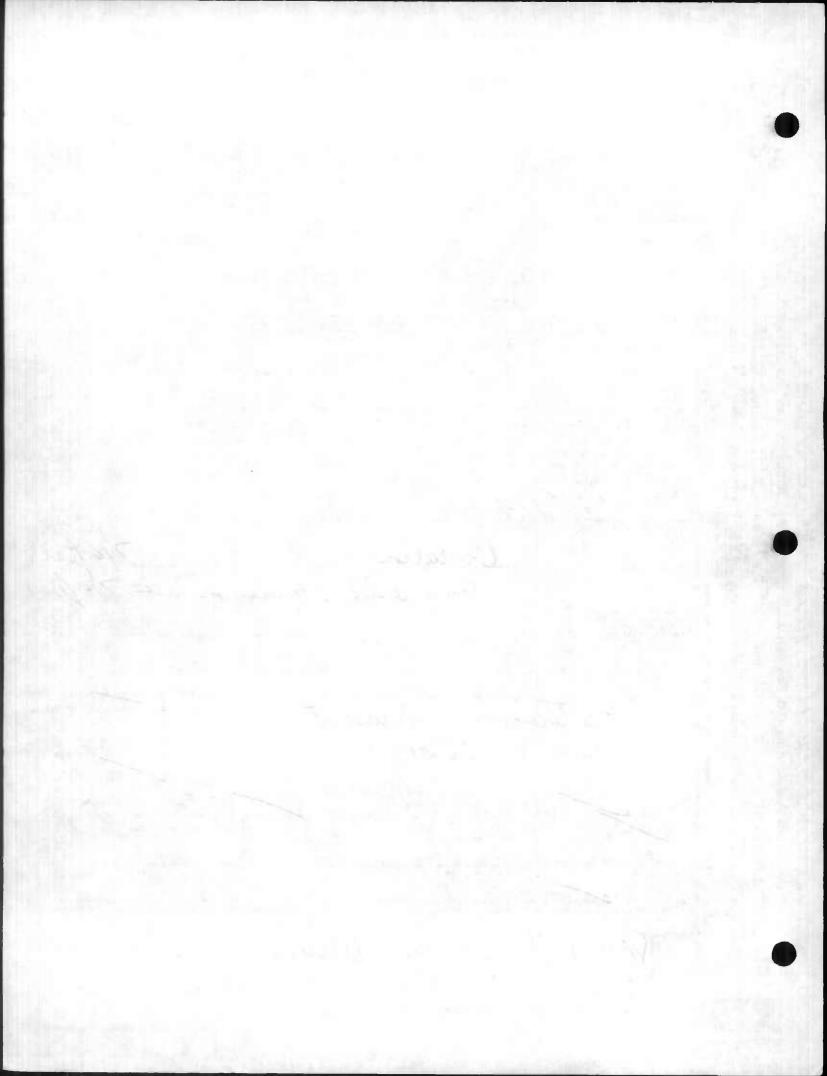
HACERSTOWN, MD 21740

NOO 11, 2000

Registrar



		4. Dependently New	- a (Final Alide	dla ( and)		C	ertificate of	Death	2. Dete of De	Reg. No.		3. Time of Death
	Physician	1. Decedent's Ner Helen Lo							Month	Day 2000	Year	5:40 a.m.
	/Medical Examiner			on, give street and	number)			4b. City, Town, or L				J.40 a.m.
	LAdimilei	Coffman	Nursin	g Home				Hagers	town	Was	shing	ton
	Funeral Director	5. Social Security 214-09-74	498	6. Sex		yrs. lest birthde Yrs.	y) If Under 1 Yeer Months Deys		8. Date of Bi (Month, D NOV •	rth ay, Year) 9, 1910		lece (State or Foreign try) yland
2	1	Usual Residence	of Decedent 10b. Count	v	10c.	City, Town or	Location				1	0d. Inside City Limits
deeth with the Meryland	notified at	Maryland	Was	hington		Hager						1⊠ Yas 2□ No
- the	or 28a-f a	10e. Street and No					10f. Zip Code			10g. Citizen of N	What Coun	itry?
fi vii	23a o	1012 Sa	lem Ave	nue				21740		Ι	JSA	
ii ii	5 E	11. Meritel Status 1 Never Mar	rried 2 Me	rried Armed	ecedent Evar in Forces? s 2 No	n U,S. 1:	3. Was Decedent of If Yas, specify Cut 1 ☐ Yes 2 ☒ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ce - Amaric ck, White,	etc.
5-0020	b y	3 🖾 Widowed		d If Yes, Year o	r Datas:	16a De	cedant's Usuel Occu			Specify 16b. Kind of B		hite
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11, 5 8	= 0 5 6	17. Fathar's Name Frank		, Last)				18. Mother's Nem	tie L.		ne)	
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/// , M;	m 27 is her trac			ces - son		971	8 Hippity	Hop Lane	, Willi	amsport,	Md.	21795
Sore,	Z 2 8	20a. Method of Dis		3 □Removal fro		b. Plece of Dis	position (Neme of rematory or other pla	eca)	Dete	20c. Location -	City or To	wn, Stete
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Baltin Permit. P	Department Important: I any Injury o page.	21. Signeture of F	unerel Service	Licensee	1. <	1	22. Name end Addr 415 E. Wi	lson Blvd		FUNERAI		
6		23a. Pert1. Entar	tha diseese, o	or complications the	et caused the d	-		ing, such es cardiac				Approximata Intervel Between
1	ysician Medical	Immediate Cause	(Finel	only one ceuse o	Dou	wite	2				7/	Onset and Deeth
2	caminer	resulting in death)	)	a	Due t	o (or as a cons	eguence of):	111	1 1	1		rich 1
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Wh the of Vita	0 0	axaminar?	100	Hospitel: 1	☐ Inpatient :	2 ER/Outpat	ient 3 DOA O	ther: 4 Nursing H		sidenca 6 Ott	ner (Specif	y)
		27. Megner of Dea	ith 5 ☐ Pendi	/4	ita of Injury fonth, Day Year	28b. Time	y W	ury et ork?	28d. Describe	how injury occur	rred	1400
Vision	seeth. tor: Al the fu	2 Accident		tigetion			M 10	Yes 2 No	204 Lanatina	(Closed and them	havar D	of Paula Mumbar
	hours after deeth.  Ineral Director: After ty filled in by the funeracal Certification:	4 Homicide	doton	mined   200. Fi	ace of Injury - A lilding, etc. (Sp.	At homa, farm, ecify)	street, factory, office		City or To	(Street and Numi own, Stete)	Der or Hure	ir Adule Number,
TO I	Funer Funer stely fill dical	29a. Certifier (Check only one)	1 Certifyi	Examiner: On the	the best of my a basis of axam enner steted.	knowledge, de nination and/or	ath occurred at the i invastigation, in my	time, dete end plece opinion, daath occu	, and due to the rred et the tima	ceuse(s) end m , date and place,	enner as s and dua to	tated. the cause(s)
To the	within 24 h To the Fun completely	29b. Signature an	d tilla of certiti	11 110			29c. Licer	nse number		29d. Date signe	ed (Month,	Dey, Year)
		1	mue	Mul		7574	1)3	665 >		Nev. 1	0	1000
		30. Name and add	s of person	who complated c	ausa of death (	Item 23a) (Typ	no. H	Agen St.	run,	MD :	717	40
NA.	State	31. Dete filed (Mo.	NOV 1	3 2000	Registrer's Si	igneture	9 Span	les				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3 Time of Death Dey **Physician** 6:30 p.m. November 9,2000
position of Death 4c. County of Death Thomas Bryan Wibberley

4a. Fecility Nama (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death Examiner 18705 Dover Drive Hagerstown
Punder 24 Hrs.
Hours Min. Washington 5. Social Sacurity Number If Under 1 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 → M 2 □ F Months 219 05 0059 81 Yrs. Director November 16, 1918 Maryland Usual Rasidence of Decedant with the Maryland 10c. City, Town or Location 10d. Insida City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 18705 Dover Drive 21742 U.S.A. death 12. Was Dacedent Ever in U,S.
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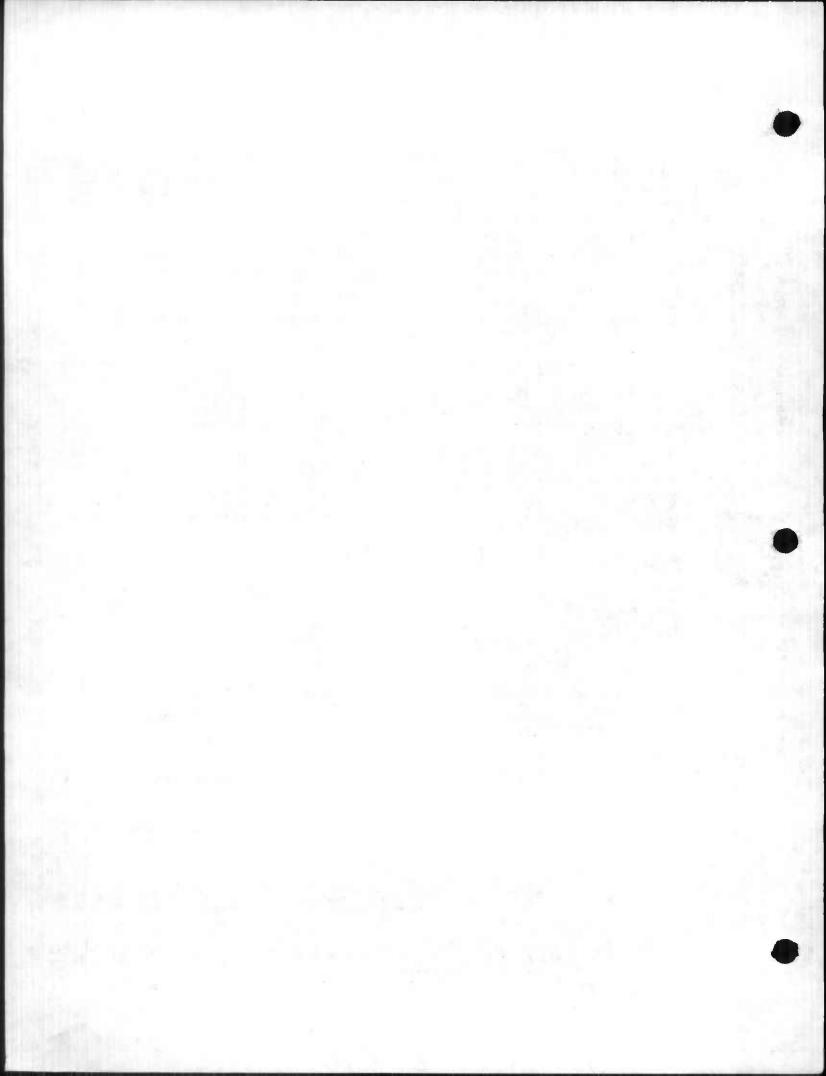
1 ☑ Yes 2 ☐ No 42-43 14. Race - American Indien, Black, Whita, atc. 11 Marital Status Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) filed within 72 hours efter 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 specify: White 1 Yas 2 No Spacify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry end Mentel Hygiene. Is marked other than Elementery/Secondary (0-12) College (1-4or 5+) Salesman General Foods Corp. 17. Fether's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked other any lollury or other traumatic event page. Be 2 Herbert Bryan Wibberley Rhoda 19e. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Wife Constance D. Wibberley 18705 Dover Drive Hagerstown, Md. 20b. Place of Disposition (Nema of cematery, cramatory or other place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 ☐ Buriel 2 🖾 Cramation 3 ☐ Ramoval from Stata Hagerstown Crematory 11/10/00 Hagerstown, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Addrass of Facility
Gerald N. Minnich 305 N. Potomac St. Funeral Home Hagerstown, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximeta Interval Batwaan Onset and Death **Physician** FMPHYSEMA Immedieta Causa (Final disaasa or condition resulting in daeth) /Medical Examiner Examiner attending physicien and for use es the burial-transit certificate be executed Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated events rasulting In daath) Last P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? the be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 2□ No 1 Yes 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to complation of cause of death? 24a. Wes en autopsy performed? peen s Completed page 2 certificate hes 2000 1 Yes 1 ☐ Yas 2 ☐ No director, 25. Was casa raferred to medical axaminar? Be 26. Placa of Daath (Check only ope) Hospitel: Othar: 4 Nursing Homa 1 Yas 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 5 Masidance 6 Othar (Specify) this funeral 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how Injury occurred Certification: After 1 Natural 5 Panding investigation death. 1 Yas 2 No or Attand efter death Director: / 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be determined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Hospital of 24 hours e Funeral D 1[Ucritying Physician: To the best of my knowledge, deeth occurred at tha tima, date end plece, and dua to tha causa(s) and mennar as steted.
2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and menner stated. 29a. Certifi To the Hosp within 24 hor To the Fune completely fi Medicai (Chi one) 29b. Sign 29c. License number 29d. Data signed (Month, Day, Year) death (Item 23e) (Type, Print) HAGENSTOWN MO 31. Data filed (Month, Dey, Year) 32. Ragistrar's Signatura State

DHMH 16 Rev 6/95

Registrar

	Decedent's Name (First, Middle,	Last)		artment of hartificate of	Death	2. Date of Dea		3. Time of Death
Physician /Medical	JAMES ROBER				4b. City, Town, or L	Novemb		2000 17 30
Examiner	4a Facility Name (# not institution, Dorchester				Cambrid		,	hester
Funeral Director	416-54-1354	6. Sex 7. A 1□χM 2□ F	ge (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Deys		8. Date of Birt (Month, Day May 12	, 1933	9. Birthplace (State or Foreign Country) Alabama
ahow dim	Usual Residence of Decedent  10a. State 10b. County  MD Dorc	hester	10c. City, Town or Lo	cation Hurl	lock			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
or 28a-f show	10e. Street and Number		1	10f. Zip Code			10g. Citizen of V	What Country?
natural, or thems 23s or 28s-f show itsel Examinet must be notified at sted by Funeral Director	56 Mill Str  11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Was Deceden Armed Forces	? ]No	Was Decedent of If Yes, specify Cub	21643 Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Rac	States a - American Indian, sk, White, etc.  Black
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Mental Hygi arked other artc event, to To Be Co	17. Father's Neme (First, Middle, L Sampson					alker		
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certificate has rector, page 2	25. Was case referred to medical				OC Plans of Doc	101	- / -	1 ☐ Yes 2 No
o p	examiner?	Hospital: 1 Inpat	tient 2 ER/Outpatier	nt 3 DOA O	26. Place of Dea ther: 4 Nursing H	ome 5 Resid		ner (Specify)
After the funeral fune	27. Manner of Death  1 Natural 5 Pending 2 Accident investige 3 Suicide 6 Could no	etion	28a. Date of Injury (Month, Day Year)  28b. Time of Sec. Injury at Work? Injury  M 1 Yes 2 No					red ber or Rural Route Number,
within 24 hours after death To the Funerel Director: A completely filled in by the f Medical Certificat	4 Homicide determin	building, e	etc. (Specify)			City or Tou	vn, State)	
within 24 hours To the Funeral completely filled Medical C			t of my knowledge, death of examination and/or in- stated.					
		A		OOs Lissa	se number		20d Data signa	d (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) WHIPPL 1245am ESTHER 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (ff not institution, give street and number, Pike Westminster
If Under 1 Year | If Under 24 Hrs. | 8. Date of Carroll 112 Littlestown 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months Deys 1 M 2 DF Hours 75 Yrs. 285-22-9725 OHIU Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits WESTMINSTER 1 Yes 2 No mD CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2712 Littlestown Pike U.S. A 21158 14. Rece - American Indien, Bieck, White, etc. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 2 No 1 Never Merried 2 Merried 1 Yes 2 No Specify Specify: WHITE rr Yes, Give Yeer or Detes: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) DomESTI2 HOMEMAKER 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Mc QUAIN INCZ MAE STARCHER 19a. Informant's Neme/Relationship (Type, Print) HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2/1/58 LAURENCE GLENWhipple Litt KSTOWN Pike 2712 WESTAINSTER, MD 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete Date NOV13 1 ☐ Buriaf 2 SCremation 3 ☐ Removal from Stete HAMPSTEAD MD. CARRILL CRENISTRY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses WESTINSTER ND. 21157 MYERS FUNDEDE HOME 91 WILLIS ST 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) END-STAGE DEMENTIA Due to (or es e consequenca ot) VASLULAR DISEASE ERIPHERA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last PARKIN SON DISEASE Due to (or as a consequence ot) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown tension 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes > No 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Completed

Be

**Funeral** 

Director

or thems 23s or 25s-1

Maryland 21215-0020

Baltimore,

Box 68760

P.O.

Division of Vital Records.

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attending physician for use as the burial Physician/M A Completed Be

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25. Wes case referred to medical examiner? 1 Yes 2 No

Menner of Death 1 Avetural 2 Accident 5 Pending investigation 6 Could not be 3 Suicide, 4 Homica

28b. Time of

Plece of Injury - At home, tarm, street, tectory, office building, etc. (Specify)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation. In my colorion, death occurred at the time, date and place, and disk the

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check or one) miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, end due to the cause(s) and menner steted. 29b. Signeture and tifle of certif

29c. License number

29d. Date signed (Month, Dey, Year) November 13, 2000

use of death (Jum 23a) (Type, Print) 125 M.D.

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DHMH 16 Rev 6/95

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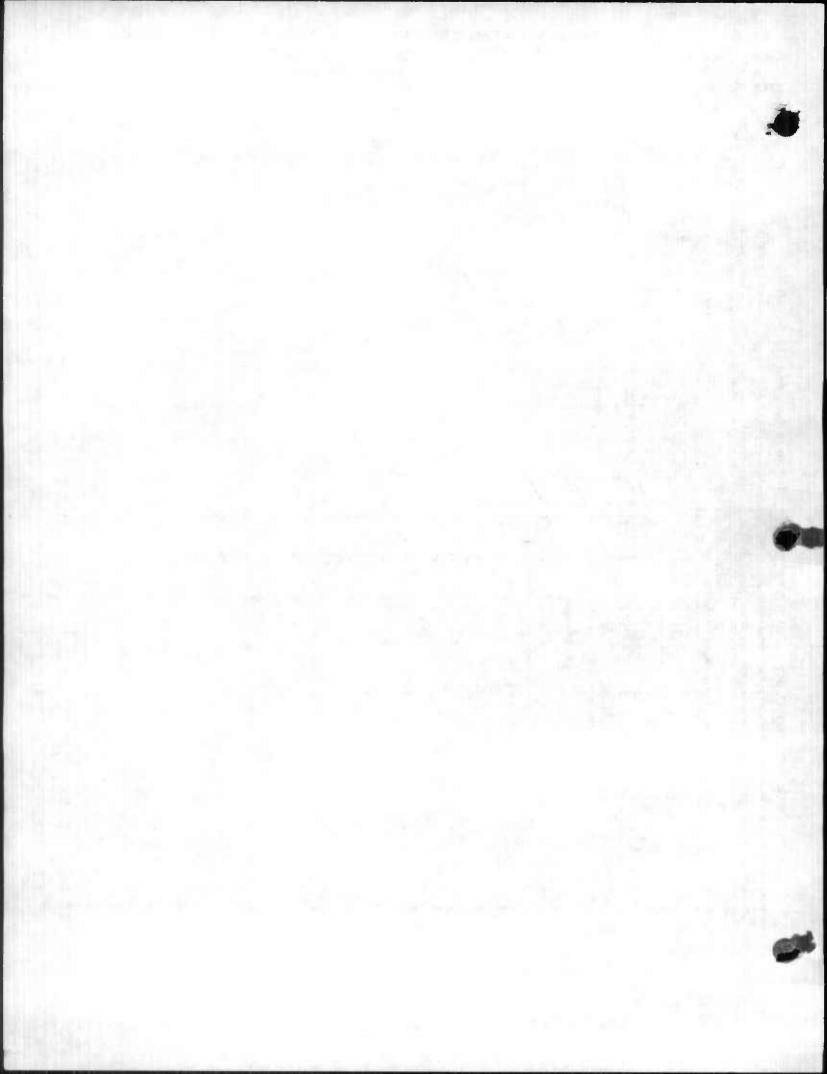
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/Medical			Cha	arles G.	. Wastle	r		Novemb		2000	11:30 A.
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uneral rector	5. Social Security 219–52-	-1949	8. Sex 1 □ M 2 □ F	7. Aga (In yrs.		If Undar 1 Yaer Months Days		8. Data of Bi (Month, Di June	rth (************************************	9. Birthpl Count Penns	aca (Stata or Foraign try) sylvania
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Yeer William Joseph Woolford 6:50pm Nov 2000 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** estminster Nursing & Convalescent Ctr. Westminster Carroll 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. Birthplece (Stete or Foreign Country) **Funeral** Months 1⊠M 2□ F Days 16-28-6361 68 Director MD Usual Residenca of Decedent with the Marylend 10e Stete 10b. County 10c. City. Town or Location show 10d. Inside City Limits If is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Cttizen of Whet Country? 419 Farm Creek Road USA 21157 death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Wes Decedent of Hispenic OrlgIn? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Btack, White, etc. Peges 1 and 2 should be filed within 72 hours efter 1 Never Married 2K Married 21215-0020 White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Etementery/Secondary (0-12) College (1-4or 5+) Security London Fog 8 Maryland 2 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be Mentai Department of Health end Mental Important: If Item 27 is marked to any injury or other traumatic ev once. Preston Earl Woolford Catherine (Unknown) 19e. informent's Neme/Reletionship (Type, Print) 19b. Maiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Germaine Woolford/wife 419 Farm Creek Rd Westminster, MD 21157 Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 11/10/00 Woodlawn, MD Lorraine Park 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licanses 22. Nerve end Address of Facility
Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157 23a. Part1. Enter the diseese, complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory erresi, shock, or heer failure. Liet only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical **Examiner** Physician/Medical Examiner S CV The lew requires that tha deeth certificate be executed the buriel-transf Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest and Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, led by the attending physician detached for use as the burie Due to (or es e consequence of): Pert ii. Other significent conditions contributing to deeth but not resulting to the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ 8 Completed 24b. Were eutopsy findings evelteble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? has certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3□ DOA After this 27. Menner of Deeth 28e. Date of injury (Month, Day Yeer) 28c. injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel daath. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Sutcide 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 6 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner steted. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ohn w. 488

DHMH 16 Rev 6/95

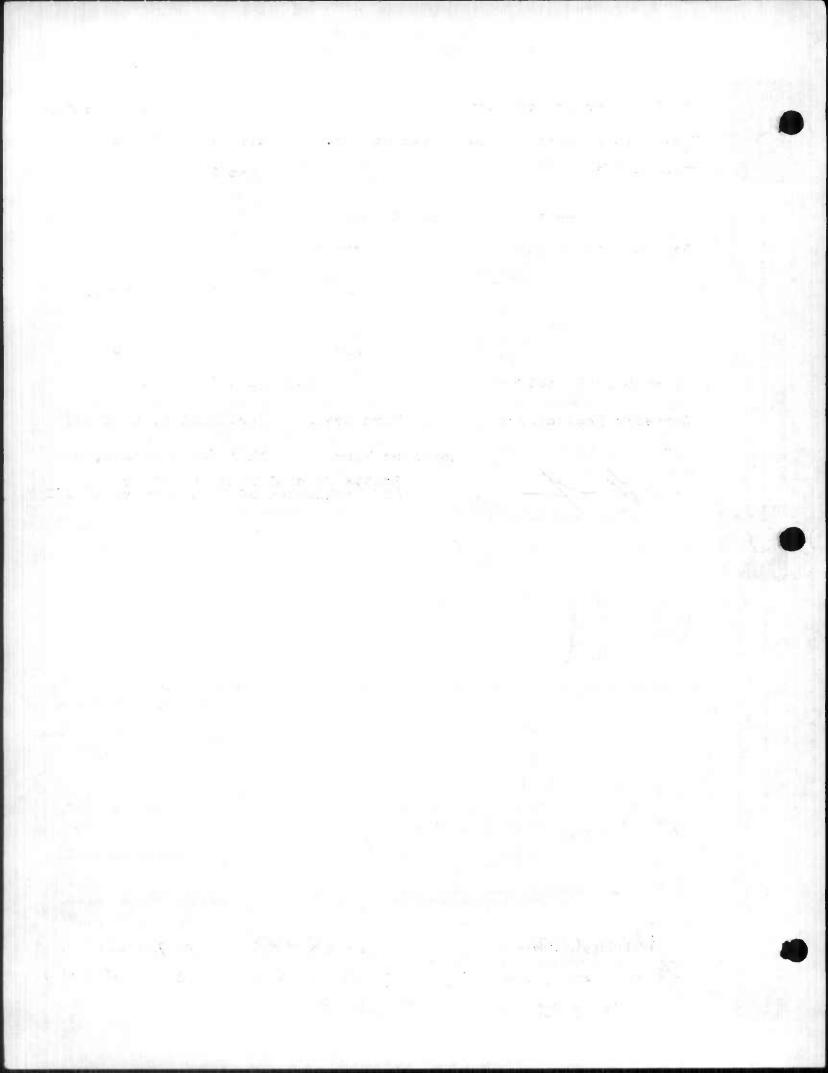
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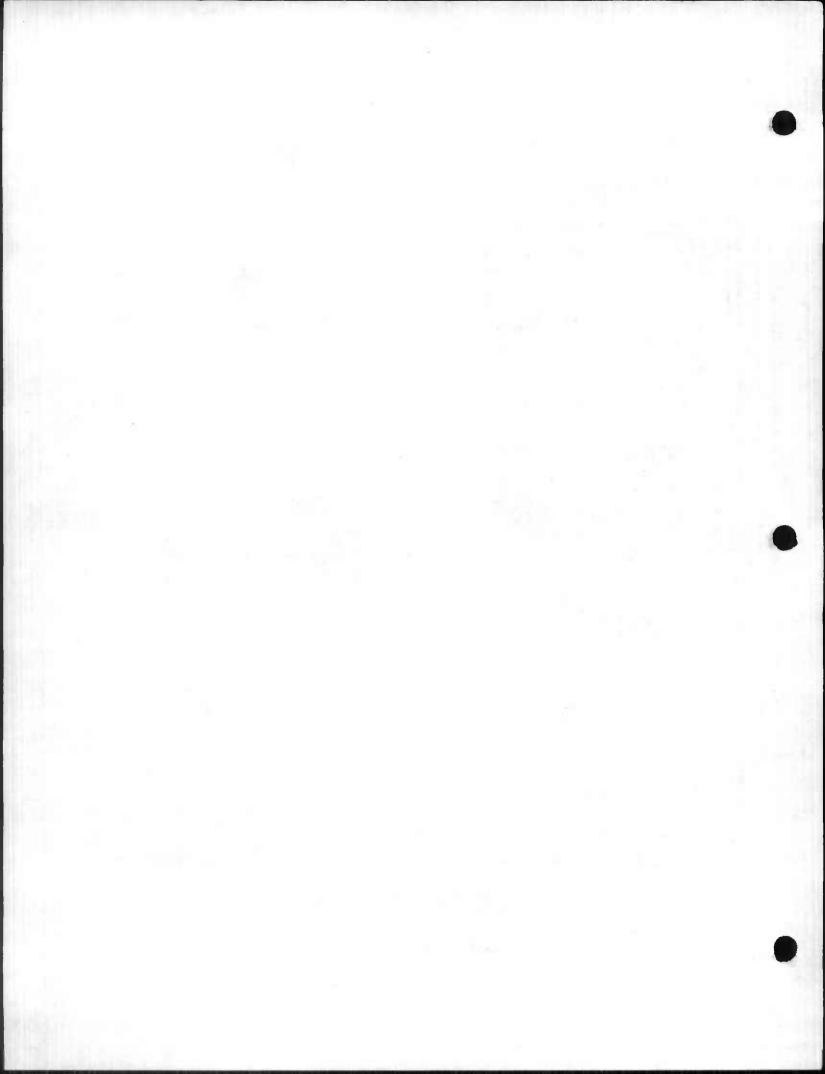
31. Dete fited (Month, Dey, Yeer)

NOV 0 8 2000

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year **Physician** 11:20/4 Charles Edward Wood November 18, 2000 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince George's 7. Age (In yrs. lest birthdey) Laure ESIONAL If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Deys Months 1 M 2□ F Yrs. Director 254-50-2966 66 Georgia June 19,1934 Usuel Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Director Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 501 5th Street 20707 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Merried 2 ☐ Married natural, or Specify: White altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondery (0-12) College (1-4or 5+) 5+ Lawyer Law permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygintportant: If Item 27 is marked other any Injury or other trauments of the pages. 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Judge Irwin Wood Thelma McKinney 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James Wood 4509 Fullerton Ave. Baltimore, Maryland 21236 /nephew 20b. Place of Disposition (Name of cematary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Union Cemetery 11/24/00 Burtonsville, MD 22. Name and Address of Fecility
Donaldson Funeral Home, P.A. 21. Signeture of Funeral Service Licenses M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Pert1. Entar the details of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. Ust only one cause on each line. **Physician** Atheroscherotic Condicuscular Discare /Medical Immedieta Causa (Final disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Causa (Disaase or injury Due to (or es a consequance of): Box 68760 Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown Mellitus Diabetes Records. by 24b. Wera autopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 2€ No 1 ☐ Yes 2 ☐ No of Vital Be 25. Wes case raferred to medical 26. Place of Death (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 4 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division ₽¥ 1 Natural 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No 2 Accidant f or Atten-after deat Director: 6 Could not be datermined 3 Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours To the Funeral completaly tilled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and mennar steted. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) A0055977 30. Neme and address of person who completed cause of daeth (Item 23a) (Type, Print) Cheverly Mary land 3001 Salvaden Hosp; ta 32/Registrer's Signeture State Registrar



Physicia /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or thems 23s or 28s-1 show any injury or other traumatic event, its Wedical Exeminar must be notified at once.

Physician /Medical **Examiner** 

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

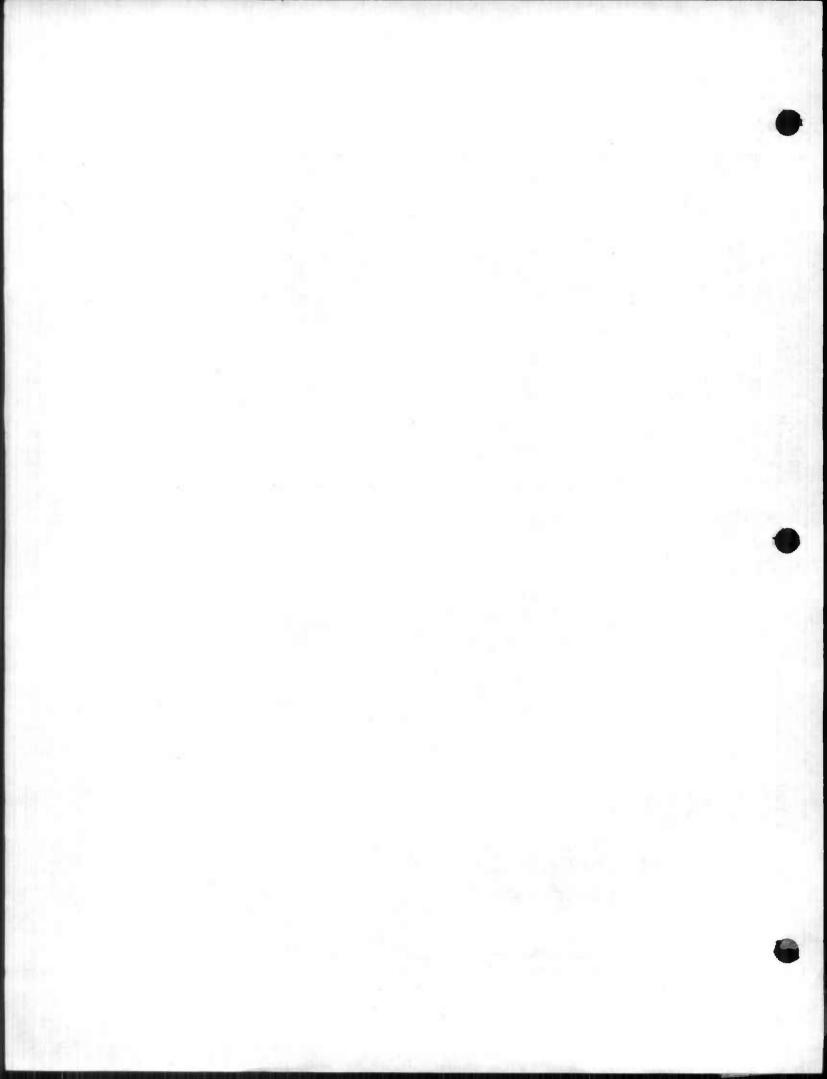
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

oarez		State of	Marylan		partment ertificate			d Mental Hy	giene ()	0 3	7468
1. Decedent's Neme (Firs	t, Middle, Las	t)						2. Dete of De			3. Time of Deeth
RULU RAN	TRO AT	BAREZ						Month Septem	ber 30	Yeer 2000	07:45 P.M
4e Fecility Name (If not in			er)				b. City, Town,	or Location of Deet			07.43 I.I
Howar	d Coun	ty Gener	cal Hos	pita	1		Colu	umbia	H	loward	1
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		XM 2□ F	28	Yrs.	·	Deys	Tiodis	Ain. 8. Dete of Bi (Month, Do May 20	1972	OCU.	y) unx
Usual Residence of Dece	County		10c City	, Town or	Location					11	Od. Inside City Limits
MD	Howar	d	100. 049	Colu						1	1 ☐ Yes 2Ã No
10e. Street and Number					10f. Zip	Code		1	10g. Citizen of	What Coun	tw? unk
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	ink	12. Wes Decede		S. 1:	3. Was Decade			(Specify Yes or No	- 14. Ra	ce - America	an Indien.
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3 ☐ Widowed 4 ☐ D		If Yas, Give Year or Dele			1 🖾 Yes 2	□ No	Specify:	hispanic	Specif	y: hi	ispanic
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Elementary/Secondary		de completed) College (1-4	or 5+)	life	ive kind of work DO NOT use	e ratired	during most or	working			
unk		nk		.71							
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			act D				ес ва.	ltimore,			- 0
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21. Signeture of Funarel S Rona	Service Licens	Wade, Di	irector			Inat	omy Boa	ard 655	W. Balti	lmore	Street
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		d									
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				Vi s					an autopsy ormed?	600	era autopsy findings eileble prior to mpletion of causa daath?
								滋	Yes 2□No	ıX	Yes 2 No
25. Wes case referred to	medical						26. Placa of	Daeth (Check only	ona)		
axaminer? 1 ☑ Yes 2 ☐ No	1-2-4	Hospital: 1 ☐ Inp	atient 2 💢	ER/Outpat	tient 3 DO	A Oth	er: 4 🗆 Nursir	ng Home 5 ☐ Res	idence 6 🗆 Ot	her (Specify	y)
2 Accidant	Panding investigation Could not be datarmined	2/30	/00	28b. Time Injur 6 : 4			y et k? Yes 2 No	Sult 28f. Location	how injury occu Dject Sh (Street and Num wn, Stata)	ot	Il Route Number,
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29b. Signeture end title of	certifier	mer	, M.	B	29c.		e number		29d. Date sign		
30. Neme and address of Joseph Per								imore, Ma			
31. Dete filed (Month, De)	, Year)	32. Reg	Istrer's Signer	ture	- 7			THOTE, IN	тутана	21201	
N	IOV 28	2000	pener	nas	13.	10	nell				

State Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year Arthus 5:00am homas Pierce SR NOVEMBER 24 2000 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Hospital at Bayview Baltimore If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 08-12-1927 Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 6. Sex Days Months Hours 1⊠M 2□ F Yrs MD 214-38-8724 Usual Rasidence of Decedan 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Anne Arundel Severn 10e. Street and Number 10f. Zip Coda 10c. Citizan of What Country? 21144 589 Pasture Brooke Road U.S.A 12. Was Decedant Evar in U,S. Armed Forcas? 1 쩘 Yas 2 □ No If Yes, Giva Yaar or Datas: 14. Raca - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status Black, Whita, etc. 1 ☐ Navar Married 2 ☑ Married 1 ☐ Yas 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Elamentary/Secondery (0-12) Collega (1-4or 5+) 12 I.R.S Government 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Thomas Arthur Margaret Kane 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Jean Arthur/ Wife 589 Pasture Brooke Road Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crametory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from Stata NOV.27, Glen Burnie, MD 4 ☐ Donation 5 ☐ Othar (Specify) Glen Haven Memorial 2000 21. Signatura of Funaral Service 22. Nama and Addrass of Facility Singleton Funeral Home P.A. 1 Second Ave. S.W. Glen Burnie, MD 21061 23a Part Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, Approximata Interval Between Onset and Death Immediate Ceuse (Finel diseesa or condition rasulting in death) / BUTRICULAR Dua to (or es a consequence of): ORONARY ARTURU Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Ceusa (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic obstructive Pulmonary disease 24b. Wara autopsy findings availabla prior to completion of cause of daath? 24a. Was an autopsy performed? Renal Pailure on Hemodialy Sie 2 No 1 Yes 25. Wes case rafarred to medicat axaminar? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1☐ Yes 2 No Othar: 4 ☐ Nursing Homa 5 ☐ Residenca 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 ☐ Yas 2 ☐ No

Examiner Examiner attending physician and for use as the burial-transit the death certificate be axecuted Physician/Medical USB BS by the a signed by to The law requires that þ been sig Completed is certificate has director, page 2 or Attending Physician: Be 2 this funeral Certification: After death. Director: A after edical

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

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**Funeral** 

Director

thams 23s or 28s-f ner must be notified

"natural", or

the Medical

Baltimore, Maryland 21215-0036

filed within

parmit. Pages 1 and 2 should be file.
Department of Health and Mental Hydi
any injury or oth.

**Physician** 

/Medical

Division of Vital Records, P.O. Box 68760, To the Funeral Digital of To the Funeral Discompletely littled in

State Registrar DHMH 16 Rev 6/95

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) Herpe awa 31. Data filed (Month, Day, Year)

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NOV28

6 ☐ Could not be

3 ☐ Suicida

29a. Certifiar

4 Homicida

(Check only one)

29b. Signature and title of certifier

N. Wolfe St. 32. Registrar's Signature

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

ORIGINAL

sm 106

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licansa number

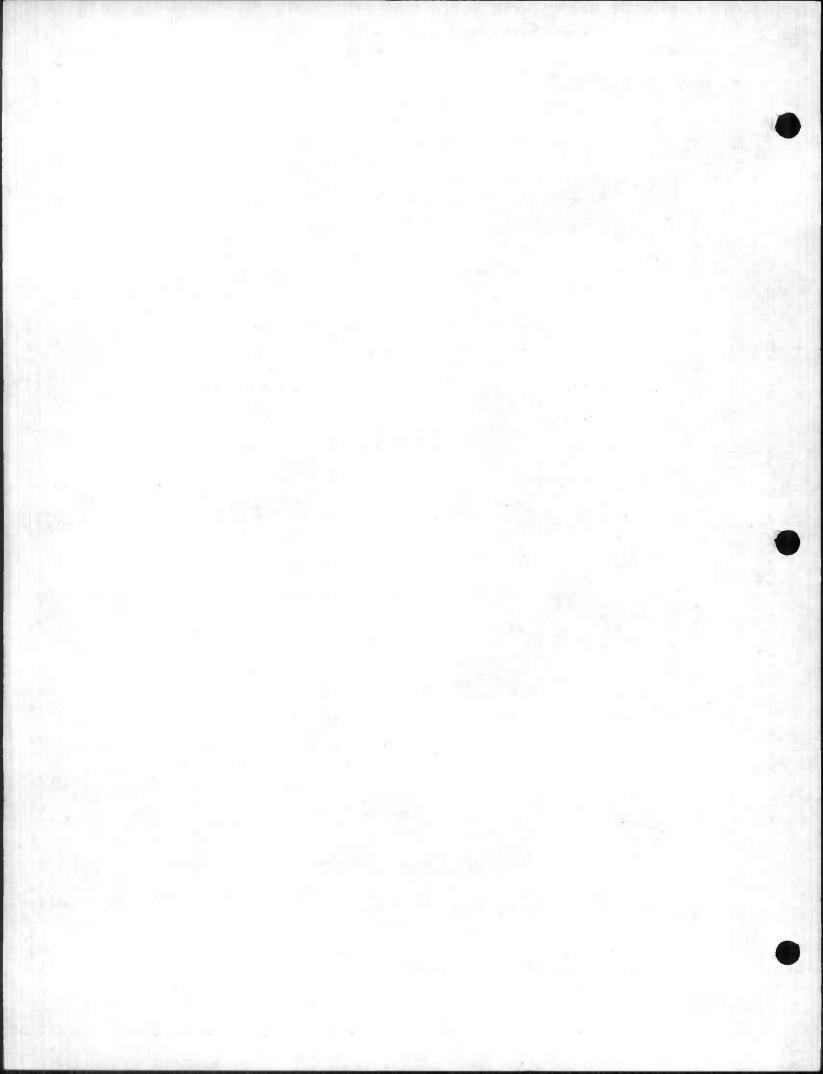
RES-000

Raltmore mo

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

NOVEMBER 24 2000



Baltimore, Maryland 21215-0036

Physici /Medic Examir

Division of Vital Records, P.O. Box 68760,

Fune Direc

without in hor me out .	12/5/00 yf		Certificat	te of D	eath	Re	ene g. No.	3	1410
1. Decedent's Name (First, Middla, Last		501-	Marie de		FL III	2. Data of Death Month	Day	Year	3. Time of Dea
James Robert A	Armstrong	I				Novembe			5:27 P
4a Facility Name (If not institution, giva						Location of Death	4c. Count		
Johns Hopkins Hosp  5. Social Security Number 6. Se		(In yrs. last bin	thday) If Under		Baltimo		N/		laca (Stata or For
	M 2180 F		Yrs. Months	Days	Hours Min			Coun	VC
10a. State 10b. County MD N/A		10c. City, Town	i more					10	0d. Insida City Lii 1∭2 Yas 2 □
10e. Street and Number 1520 Edison Hic	rhwav		10f. Zip	Code 1213	7	10	g. Citizen of	What Coun	try?
11. Manital Status	12. Was Decedent E	ver in U.S.			panic Origin? (	Specify Yes or No-	USA 14. Ra	ce - Amaric	an Indian,
1 Never Married 2X Married 3 Widowed 4 Divorced	Armed Forces? Name of Process 2 □ No If Yes, Give Year or Dates:		If Yes, spe	cify Cuban,	, Mexican, Pue	rto Rican, etc.)	Ble	rck, White, o	etc.
15. Decedent's Edu		16a.	Decedent's Usua			1	6b. Kind of B	Business/Ind	lustry
(Specify only highest grad	Collega (1-4or 5+		(Giva kind of wo lifa. DO NOT u	ise retired)			Vatio	nal (	Gypsum
11th 17. Father's Neme (First, Middla, Last)		I F	OLKILL	-		ame (First, Middla, M	_		3 poun
Addie Armstrong	g				Isabe1	le Simp	son		
19a. Informant's Name/Reletionship (T)		111/2	1000			Balto.			Code)
Jessie B. Armsı 20a. Method of Disposition	rong-wire		Disposition (Na/		пму.		Oc. Location		wn Stete
1 □ Burial 2 □ Cremation 3 □ F		camatai	ry, cramatory or o	othar place)	)	54.0	ou. Coodiioi.	Ony 0. 10	min Ololo
4 ☐ Donation 5 ☐ Other (Specify)	)	Gasto	n Bap.			m 12/33	Gasto	n, No	C
21. Signature of Funeral Service Liberts	9	Gasto	22. Name ar	Chu nd Address	rch Ce	n 12/3 atter Fulls Pkwy	neral	Home	e Inc.
	~ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		22. Name ar 2501	Chu nd Address Gwyn	rch Ce of Facility Nu ns Fal	itter Fu	neral . Bal	Home	MD 2121 Approximate Interval Between
21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or compleshock, or heart failura. List only of	liculions that caused to	he death. Do r	22. Name ar 2501	Chu nd Address Gwyn de of dying,	rch Ce of Facility Nu ns Fal , such as cardie	itter Fu	neral . Bal	Home	e Inc. MD 2121 Approximate Interval Between
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29b. Signature and title of certil

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 27, 2000

30. Name and address of pany who complet ed cause of death (Item 23a) (Type, Print)

M

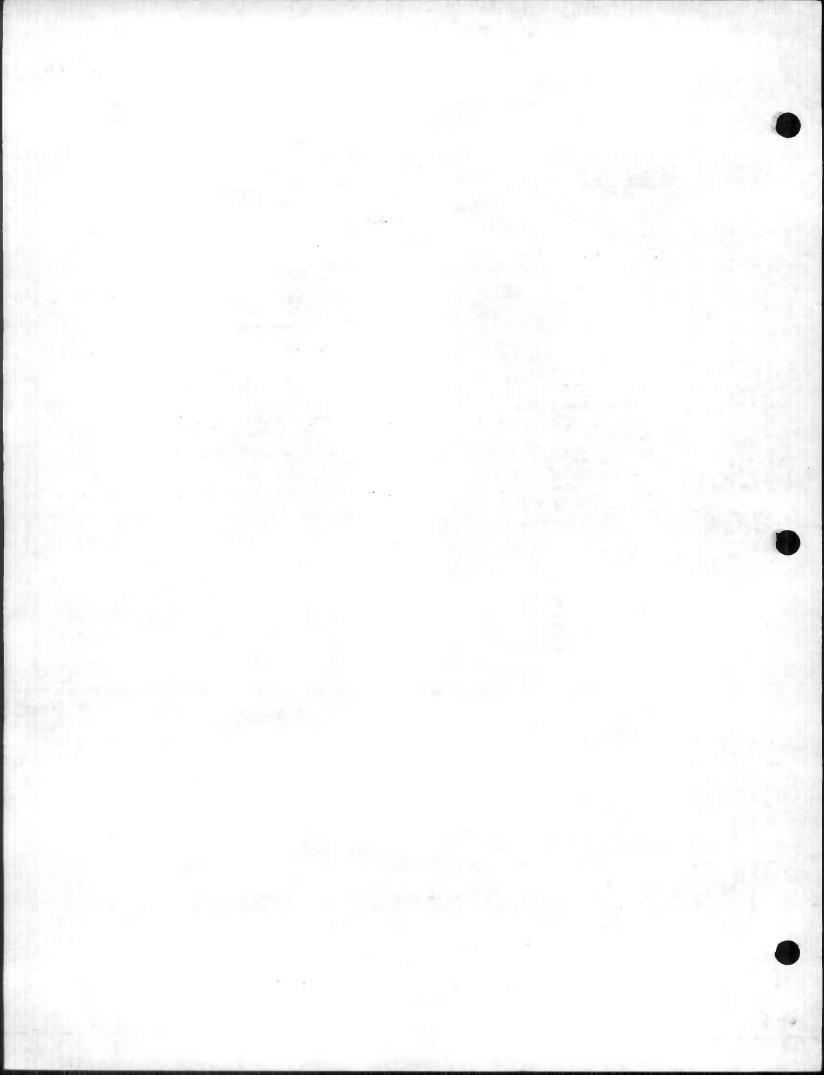
111 Penn Street, Baltimore, Maryland 21201

State Registrar

JAOK N 31. Date filed (Month, Day, Year) NOV 28

32. Registrar's Signature

ORIGINAL

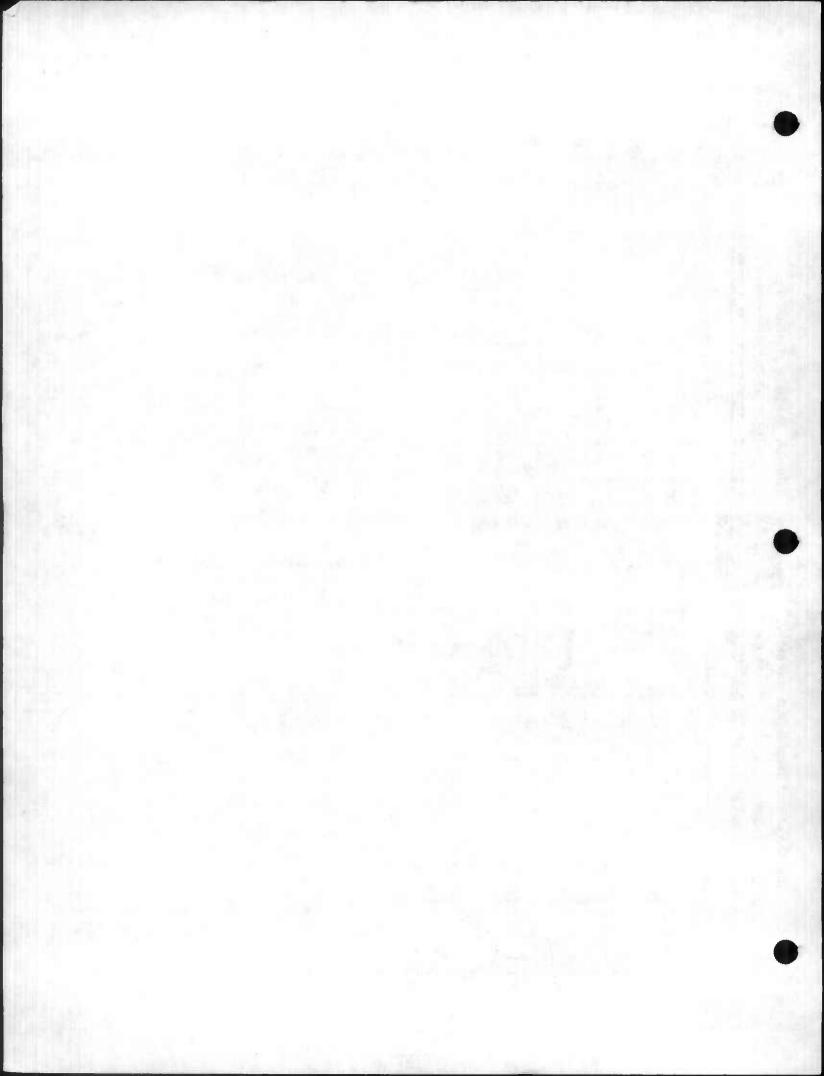


## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 371.71

CHARLES	ADDISC	M		State
012.11.11.00				State
AMEND I	IEM: #8	PFR F.H.	G790	12-12-00 WR.

AMEN	D ITEM	: #8 PER F.H. G790 12-11	2-00 WR.	Ce	rtificate o	f Death		Reg. No.	0 3	1411
D	hysician	1. Decedent's Neme (First, Middle, Las		1 3 5			2. Dete of D Month			Time of Death
	/Medical	Charles Joseph				T	NOV.	18, 200		0435 AM
Ε	xaminer	4a Facility Neme (If not institution, give 3153 KESWICK R	OAD			BALTIM		N/A		
	neral ector	2.0 10 0100	9x 7. Age (In yrs 58	. lasf birthdey, Yrs.	Months De		fin. 8. Date of Bi (Month, D July	9, 1942	9. Birthplece Country) Mary La	(State or Foreign
1	e u	Usuel Residence of Decedent  10a. Stafe 10b. County	10c. C	ity, Town or L	ocation	1			10d. I	Inside City Limits
e Mary	notified	Maryland N/A		В	altimore	9				Yes 2□No
di di in	2 0	10e. Street and Number 3153 Keswick Road			10f. Zip Code 212			10g. Citizen of V USA		
	Examiner must	11. Meritel Sfetus  1 □ Never Merried 2 ☑ Merried  3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in l Armed Forces? 1 Tyes 2 No If Yes, Give Yeer or Detes:	U,S. 13.	Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☒ N		(Specify Yes or Nuerto Rican, etc.)	o- 14. Rac Ble Specify	e - American Ir ck, White, etc. w: Whi	
2 2	dical	15. Decedent's Ed (Specify only highest gra	ucetion de completed)	16a. Dece (Give	dent's Usuel Occ	cupetion ne during most of ired)	working		usiness/Industr	
with a	Comple	Elementery/Secondery (0-12)	College (1-4or 5+)	Tru		ver		Indepe	ndent 1	rucking
D DE		12 + 17. Father's Neme (First, Middle, Last)			On Di		Neme (First, Middle	, Maiden Sumen	10)	-
Alemba Alemba	fic ever	Charles Poole Ad	dison			Lolli	e Wrig	ht		
2 sho		19e. Informent's Neme/Reletionship (7					Rural Route Num			
and and	2	Debra Addison	Wife			.ck Road,	Baltimo	7		
Pages ant of F	9 9	20e. Method of Disposition  1 Buriel 2 Cremetion 3   A Boarding of Dotter (Secretary)	Removel from State	cemetery, cre	osition (Name of matory or other p Veterar		11/27	20c. Location		
1	injur.	4 Donetion 5 Other (Specify 21. Signafure Funerel Service Licen.			2. Neme end Add		11/2/	Garriso	n rores	ST, MD.
1 201	118	Dum !	3 Denn	) 1	Burgee-H	lenss-Sei	tz Funer	al Home,	Inc. 2	21211
		23e. Pert 1. Enter the disease, or companies shock, or heart tailure. List only of	plications that caused the dec	oth. Do not en	3631 Fall ter the mode of c	1s Road, lying, such es cel	Baltimo diec or respiratory	re Mary	land App	proximete ervel Between
Exam	rial-transit Examiner	disease or condition resulting In death)  Sequentially list conditions, if eny, leeding to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events	b	or es e conse	quence of):	1201001130	/	7) 3 2/18/2		
= 5	X .	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (	or es a consec	quence of):				1	2
0 00	sici	Part II. Other significant conditions co	ntributing to deeth but not re	sulting in the u	inderlying ceuse	given in Pert I.	23b. Dic	tobacco use co	ntributa to the	cause of death
ta ta	be detached for use	CHRONIC OBST	RULTIUK PU	LMEN	Avey DI	SEASK	10	Yes 2□ No	3 Probabl	y 4 Unknow
requires that	should be							s an eutopsy	eveileb	autopsy findings ble prior to
a a a	O D							ECTION	comple of deet	etion of cause
off.	Com						1 🗆	Yes 20 No	1 ☐ Ye	s 2 No
Physician: Th	De Ctor	25. Wes cese referred to medical examiner?	Hospitel:			- 45 0	Deeth (Check only	one)		
ding Physic	P	27. Menner of Deeth  1 🖾 Netural 5 🗆 Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. In		g Home 5X Res 28d. Describe	how injury occur		
or Attending after death.	ed in by the funer Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury · At I building, etc. (Special				28f. Location City or To	(Street end Numb own, State)	per or Rural Ro	oute Number,
Hospital n 24 hours	fely fill	29e. Certifier (Check only one) 1 Certifying Phy one) 1 Medicat Exam	rsician: To the best of my kn iner: On the basis of examin end menner steted.	owiedge, deet etion and/or in	h occurred et the	time, dete end pl y opinion, deeth o	ace, end due to the ccurred et the time	cause(s) and me , dete end plece,	enner as stated and due to the	d. cause(s)
To the	N N	29b. Signeture and fill of certifier	1 0			ense number		29d. Date signe	_	
	VX)	30. Name and address of person who c	ompleted cause of death (tea	W1)		O.C.M.E		NOV.	वर्ष , व	2000
M	1/4	MARM G. NIPP				et, Balti	more, Ma	ryland 2	1201	
R	State egistrar	31. Dete filed (Month, Day, Year)	32. Registrer's Sign	eture	Brank.	,				



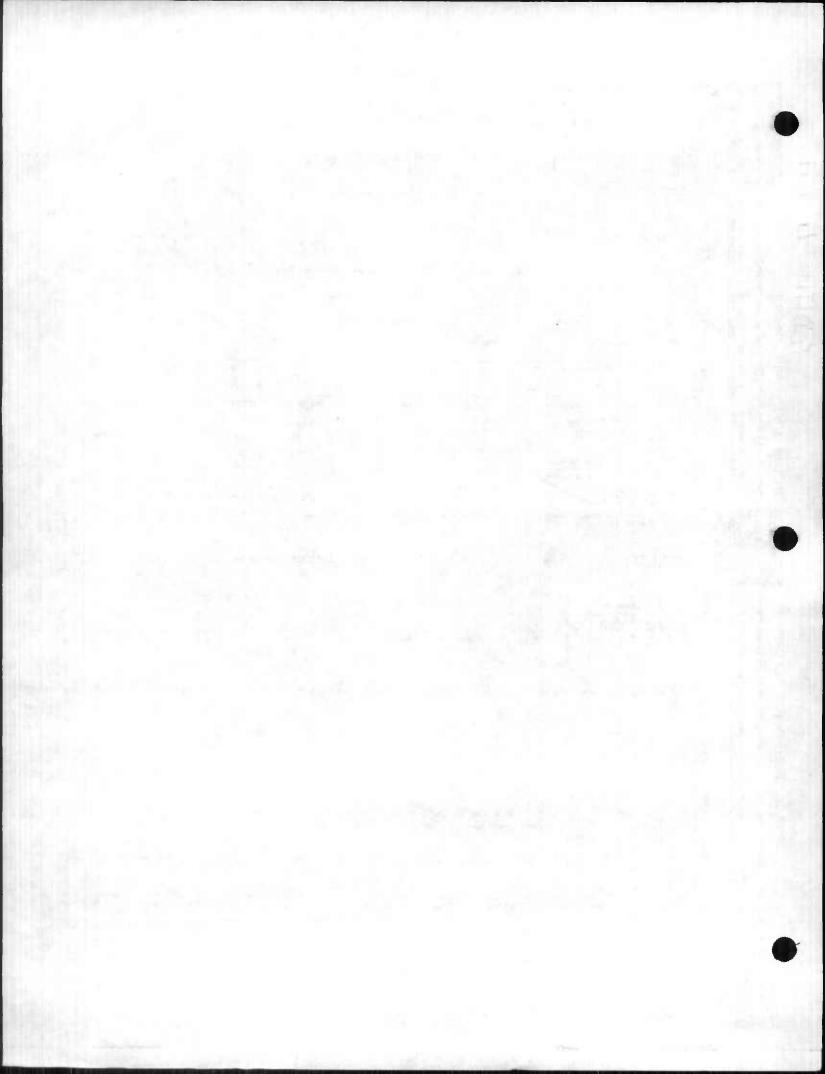
## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 37472

						Ce	ertifica	te of	Death			Reg. No.	00	J	1416
			1. Decedent's Nama (First, Middle, Li	st)							2. Data of De Month	eath Day	,	Year	3. Tima of Death
9	Physici /Medic		Edith Bla	anch							Novemb	er 2		2000	12:00 am
	Examir		4a Facility Name (If not institution, gi		um <i>ber)</i>						ocation of Deat			of Death	
	<u> </u>		Stella Maris at		l = 4 . 4		1 K Hode	r 1 Year	Balti				/A	0.0:4	(0)
	Funeral Director		218-32-8604	Sax 1□M 2⊠F	7. Age (in yn	s. last birthdaj Yrs.	Months		Hours	Min.	8. Date of Bi (Month, Di March 4,	1914		9. Birthp Coun	lace (State or Foreign try)
	pue **		Usual Residence of Decedent  10a. State 10b. County		10c. C	City, Town or I	Location							11	0d. Inside City Limits
	with the Maryland a or 28a-f show Lbe notified at	octor	MD N/A		В	altimore	-								1 ☐ Yes 2 ☐ No
	th with the 23s or 2 and be m	ai Dire	10e. Street and Number 4215 Sheldon Avenue					206				-	S.A.	Vhat Coun	lry?
020	urs after death with the Maryla rsf., or theme 23s or 28s-f show Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XXWidowed 4 Divorced	Armed F	2 X No	U,S. 13	Mas Dece If Yas, spe 1 Yes	cify Cub	dispanic Origan, Mexicen  Specify:	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	0-		a - Americ k, White, d	etc.
2-0	72 hours natural', dical Exa	eted	15. Decedent's E (Specify only highest gr		)	16a. Dec	edent's Usu	al Occup	oation during most	t of work	rina	16b. Ki	ind of Bu	siness/Inc	dustry
121	within then the Man	Be Completed	Elementary/Secondary (0-12)		(1-4or 5+)	lifa.	nemaker	ise retire	d)				own ho	<b>2</b>	
9	Hygie Merie	S	17. Father's Name (First, Middle, Las	()		nu	lellaker		18 Mothe	r's Nam	e (First, Middle				
an	od be de	B	Jesse	Lehmar	1				Cathe			Conr		,	
Maryland 21215-0020	2 should and Minister the mark	To	19a. Informant's Name/Relationship  Dorothy Saul- daught	(Type, Print)					and Number	or Au	ral Route Numb		r Town,	State, Zip	Code)
	Heath Heath Chert		20a. Method of Disposition		20b.	Place of Dis			ilue, be	AT CITI	Data			City or To	wn. Stale
Baltimore,	Paget mart of ant: If It jury or o		1X Burlal 2 ☐ Cremation 3 [	fv)	IMO	st Holy				1	1/28/00	Balt	timore	e, MD	
Ball	Depart Import any in		21. Signature of Funeral Service Lice	willia	am G. Dau				ess of Facility and Rd.,	Leo	nard J. F imore, M			al Hom	e, Inc.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that	caused the de	ath. Do not e	nter the mo	de of dyi	ng, such as	cardiac	or raspiratory	arrest,			Approximate Interval Between
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	a	-	ctusto (or as a cons			olon	C.	unec				Onsat and Daath
,00	eath certificate be asscuted attending physician and for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to	(or as a cons	equence of	:							
× 68760,	ding physics as the t	2	that initiated events resulting in death) Last	d	Due to	(or as a cons	equence of)								
Bo	death of attended for u	cian									1			- 1	
P.O.	t the d	Physician/	Part II. Other significant conditions	contributing to	death but not re	esulting in the	underlying	causa gi	van in Part i				No No	3 Pro	the cause of death? bably 4 Unknown
Records,	been sign ahould be	Completed by										s an auto lormed?	psy	av	ere autopsy findings ailable prior to mpletion of cause death?
	The law ate has page 2	EO									10	Yes 2	No	10	☐ Yes 2☐ No
ta		Be C	25. Was case referred to medicel						26. Place	of Dea	th (Check only	one)			
Division of Vital	fing Phi After thi funeral	5	axaminer?  1 Yas 2 No  27. Manner of Death 1 Natural 5 Pending investigation	28a. Date (Mo	Inpatiant 2 of Injury nth, Day Year)	ER/Outpati 28b. Time Injury		28c. Inju Wo			1			n hospiy	
Divisi	- 0 - 5	Certification:	3 Suicida 6 Could not l determined	e of Injury - At ding, etc. (Spec	home, farm, s	street, facto	ry, office			28f. Location City or To			per or Rure	al Route Number,	
	n 24 hours e-Foneral pletely file	edical	29a. Certifier Certifying P (Check only one) 2 Medical Exa	miner: On the I											
	ST S	×	29b. Signature and title of certifier	^			25		sa number				-		Day, Year)
	M	)	De Hour The	0 ~		am 00-1 7	o Deint		DYO						7,2000
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	Sta	ite	NOV 2 8 2000	Lanes	Registrar's Sig	la	1.								

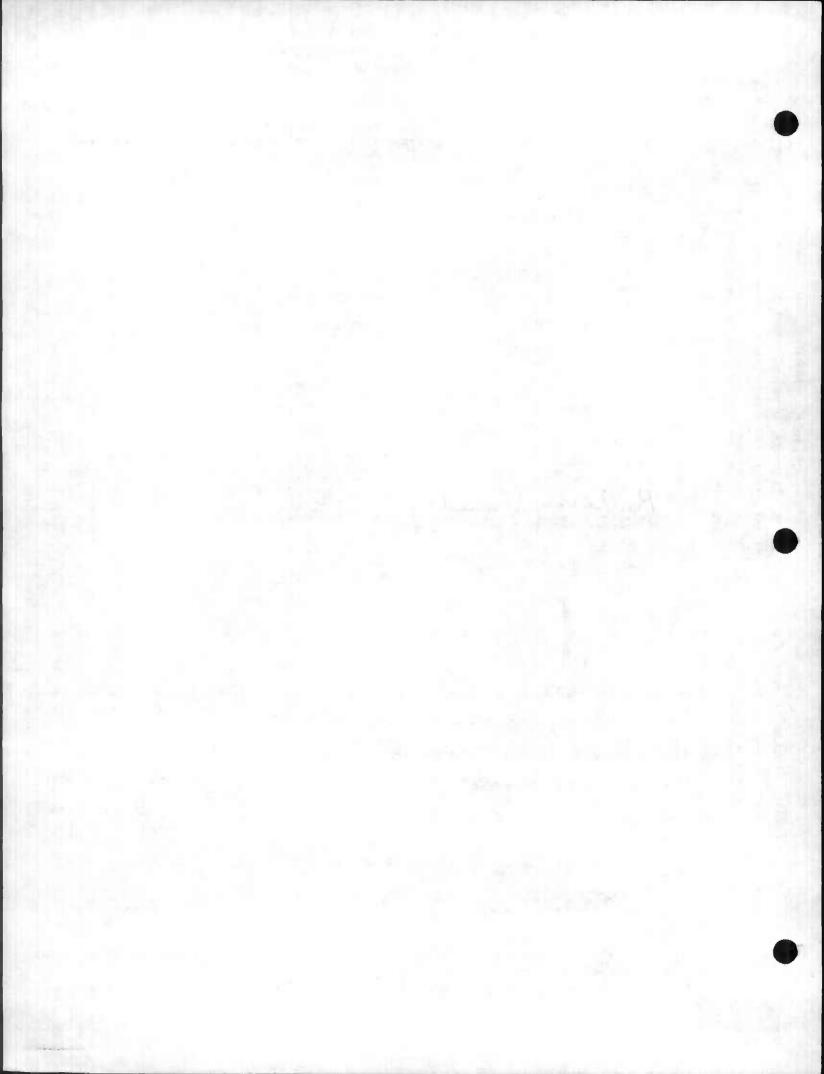
DHMH 16 Rsv 6/95

SDITH BLANCH



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O.

	1. Decedent's Name (First, Middle, La:						2. Date of Deat	h Dev	Year 3.1	ime of Death
ician		Mai	rie M	f B1	ack		NOVEMBE		0 - 1	50 A.W
dical . iner.	4e Facility Neme (If not institution, give	e street end number;			4	b. City, Town, or Lo		4c. County	-	
	FRANKLIN SQUAR	E HOSPITT	AL CEN	TER		ROSEI	ALE	BA	LIIMOR	E
	5. Social Security Number 6. S	ex 7. A	e (In yrs. last bii		der 1 Yeer	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day,			State or Foreign
	178–10–7912	□M 2XF	85	Yrs.	lis Days	riours wiii.	Aug. 3	1915	PA	
	Usual Residence of Decedent		140 00 7						Local	
	10a. Stele 10b. County Md Balt	imore	10c. City, Tow	n or Location	Fo	sex				side City Limits ☐ Yes 25\text{No}
		Imore				SEX				1105 ZQ[NO
Oli de la	10e. Street and Number			10f.	Zip Code		10	0g. Citizen of V		
-	1017 Foxchase L			1 111		21221		USA		
l	11. Marital Status	12. Was Decedent Armed Forces		13. Was De it Yes, s	pecify Cuba	spenic Origin? (Sp n, Mexican, Puerto	ecity Yea or No- Rican, etc.)		e - American inc ck, White, etc.	iian,
	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀	No	1 ☐ Yes	2 No	Specify:		Specify	White	9
-		Year or Dates:	100	Docadent's Li	laval Ossuma	atlon		16h Kind at Ru	usiness/Industry	
	15. Decedent's Ed (Specify only highest gra	ide completed)	108	(Give kind of	work done d Tuse retired	ation funing most of work )	ring	TOD. NITO OF BU	asinessamoustry	
	Elementary/Secondary (0-12)	College (1-4or	5+)			tomist		Mea	ckCo.I	nc
1	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, N	Maiden Sumam	10)	
-	Walter Mille	r				Carrie	MAe Ku	staboro	der	
1	19a. Informant's Name/Relationship (		198	Mailing Adds	ess (Street a	and Number or Rui				)
	Sharon Terry / n						Baltimor			
+	20a. Method of Disposition	rece	20b. Place 0	f Disposition (/ ry, crematory o					City or Town, S	tete
	1 Burial 2 Cremetion 3			ry, crematory of twn Ceme		11/25/	2000	Balti	imore N	(ID
-	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen				and Addres		2000	20201		
	21. Signature of Pulleral Service Licer	()	01			Funeral	HOme of	Essex		
1	1. Len	y Com	elle	1 300	0 MACE	AVe. Ba	1timore	Md. 212	221	
	23a. Part1. Enter the disease, or com- shock, or heart failure. List only	op cause on each I	ine.	not enter the h	node ot dying	g, such as cardiac	or respiratory erre	951,	inter	oximate val Between et end Deeth
	Immediate Cause (Final			,						, 0110 00011
	disease or condition resulting in death)	a	URD SE	PSIS				200	1	
			Due to (or as a	consequence	of):				1	
		b								
1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury		Due to (or as a	consequence	01):					
ı	Cause (Diseese or injury that initiated events	c	2							
	resulting in death) Last		Due to (or es e	consequence o	01):					
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ı	1 -						24a. Was a		24b. Were au	topsy tindings
	KENAL INSUFFICI	ENCY, -	DEMEN'	TIA			perform	med?	complet of death	prior to ion of cause
1	Car land Car	3					1 🗆 Ye	es 25No		
	CORONARY ARTERY	DISEAS	5						I L Tes	2□ No
1	25. Was case reterred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:			DO Othe	er.	th (Check only on			
t		28e. Date of inju		utpatient 3LI Time of	DOA	4 U Nursing He	ome 5 Reside			
		(Month, De		Injury	Work	(? Yes 2□No	200. 0000100 11	on injury coods.		
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	27. Manner of Death  1 PAtatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	•	ium. At home to		lory, onice		City or Town			
3	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	e 28e. Place of In	jury - At home, to c. (Specify)	ziiti, 91/001, 100						
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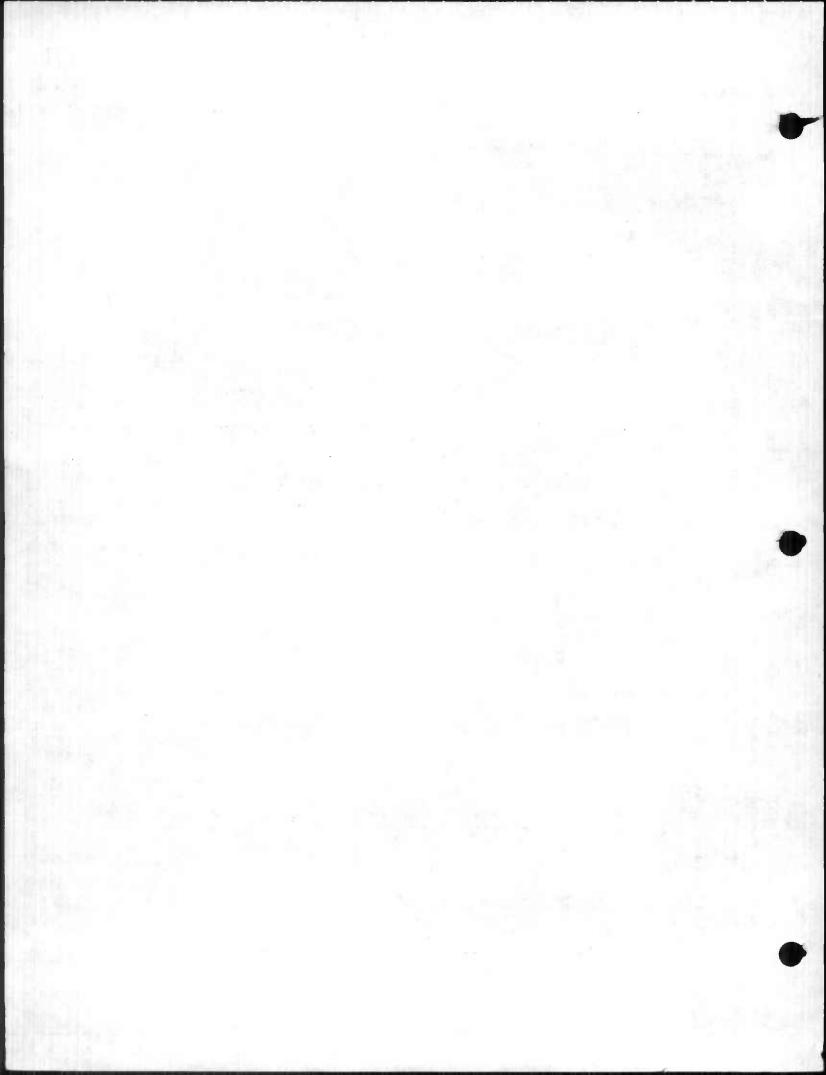


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			C	ertificate o	f Death		Reg. No.	3	1414
Physician	1. Decedent's Name (First, Middle, L	est)				2. Date of De Month	Dey	Year	3. Tima of Death
/Medical Examiner	Camillus 4a Facility Name (If not institution, gi	ive street end number)		Bat	tle 4b. City, Town, or	11 Location of Deat	-	000 of Death	4:00a.m
Examine.	2611 Garrison			Williadae d Vac	Baltimo				
Funeral Director	5. Social Security Number 6. 243-50-0597 Usual Residence of Decedent	MEN ARE	68 Yrs	Months Day		(Month, De	15 32	9. Birthple Count N	ace (State or Foreign ny) • C •
yland	10a. Stete 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits
death with the Maryland rms 23s or 28s-f show rms to nutried at	MD NA		Baltin	nore					XXves 2□No
vith the Ma to 28-f a be notified Director	10e. Street and Number			10f. Zip Code		100	10g. Citizen of \	What Count	ry?
erai	2611 Garrison	Blvd apt	D Ever in U.S. 1		1216	Specify Ves or No		S.A.	an Indian
er, or hems 234 Exemples must by Funeral	1 Never Merried Merried 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 N If Yes, Give Yeer or Detes:	4o	If Yes, specify Co	f Hispantc Origin? (Suban, Mexican, Puerlo Specify:	to Rican, etc.)		ck, White, e	etc.
ner than "naturel", rt, tra Modeal E. Completed by	15. Decedent's E			cedent's Usuel Occ	cupation ne during most of wo	rkina	16b. Kind of B	usiness/Ind	ustry
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27 ie ma r traum	Mary Battle-Wi	fe	26						21210
	20e. Method of Disposition		20b. Plece of Di cemetery,	sposition (Neme of cremetory or other p	son Blvo	Dele	20c. Location	City or Tov	wn, Stete
= 0	1 M Burial 2 Cremetion 3 4 Donetion 5 Other (Spec		King N	demorial	Park	11/27/0	0 Rand	alls	town, Md
Important: any injury 2028.	21. Signature of uneral Service Lies	90566	1	22. Name and Add	ress of Facility H West				
2 6 0	Mary 18	honna	6	4300 Wa	bash Ave	e, Balt	imore	Md	21215
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ian/		d							
e t	Pert II. Other significant conditions	contributing to death be	ut not resulting in th	e underlying cause	given in Pert I.		Yes 2200		the causs of death?
should be det		1330			100		s en eutopsy omed?	av8	ere autopsy findings allable prior to
rector, page 2 shi		Y STAR ST						of c	mpletion of cause death?
Con Con						10	Yes 2 No	10	Yes 20 No
director, page 2	25. Was case referred to medical examiner?	Hospitel:		# cD = (	Whor:	ath (Check only		10	,
Pie T	1 ☐ Yes 2 ② No 27. Menner of Deeth	28a. Dete of Injur	ry. 28b. Tim	e of 28c. In	4 U Nursing 1	Home 5 Res 28d. Describe	how injury occur		9
atior	1 ANeturel 5 Pending investigeti		Year) Inju		Vork? ☐ Yes 2 ☐ No				
led in by the funeral Certification:	3 Suicide 6 Could not determine		ury - At home, farm	, street, factory, offic	Ce	28f. Location City or To	(Street end Num. own, Stete)	ber or Rura	l Route Number,
To the Funeral Director: After the completely filled in by the funeral Medical Certification:		thysician: To the best of the basis of end menner ste	examinetion end/o						
To the	29b. Signeture and title of certifier	P	111		ense number		29d. Date signe		
	Mukelon	bson	. Ms	RE	5-000		NOVEMBE	R 22	2,200
)	30. Name and address of person who	completed cause of d	eath (Item 23a) (Ty	pe, Print) SEN	TER				
	31 Dete-filed (Month Day Year)	/ 32 Begistre	are Signature						

Registrar

NUV 2 8 2000" DHMH 16 Rev 6/95



### Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Bradford 1:30 M. Alberta NOV 20 2000 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number 4c. County of Death Hospital 7. Age (In yrs. last birthday) P.G. 7. Wash. Washington ity Number If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 1□ M 20 F Months Days 87 578 28 5756 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2□ No Wash. D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? St, NE. 20017 5056 45A 12. Wes Decadent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Stetus 1 Never Married 2 Married 1□ Yes 2NNo Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Delia B. Norrell Steven mitchel 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister 20904 20b. Plece of Disposition (Name of cametery, crematory or other place) Silver Spring mb 200 Date 200. Location - City or Town, State Neva Sanders -20a. Method of Disposition 1 Burlel 2 ☐ Cremation 3 ☐ Removal from State 11/27/00 Brentwood MD Ft. Lincoln Cem. Donetion 5 Other (Specify) 22. Name and Address of Fecility John T. Rhines CC00273. 3030-12th. St. NE Wash DC 20017 ert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): HEART FAILURE ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Due to (or es a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24a. Was an autopsy performed? 1□Yes 2₩ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 1 MInpatient 2 □ ER/Outpatient 3 □ DOA

**Physician** /Medical **Examiner** Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examples.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

the Maryland

death

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Physician/Medical þ Completed Be 2 Certification:

I or Attent after deat Director: To the within 2 To the

Division of Vital Records, P.O.

1 Yes 25 No 27. Manner of Deeth 1 Naturel 2 Accident 3 ☐ Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury NIA Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Yes 25 No

NIA

MARYLAND

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated.

29b. Signature and title of certifier Victor E. Jerry M.D.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D20986

29c. License number

November 21, 2000

29d. Dete signed (Month, Day, Year)

20745

11701 Livingston Rd

29a. Certifier

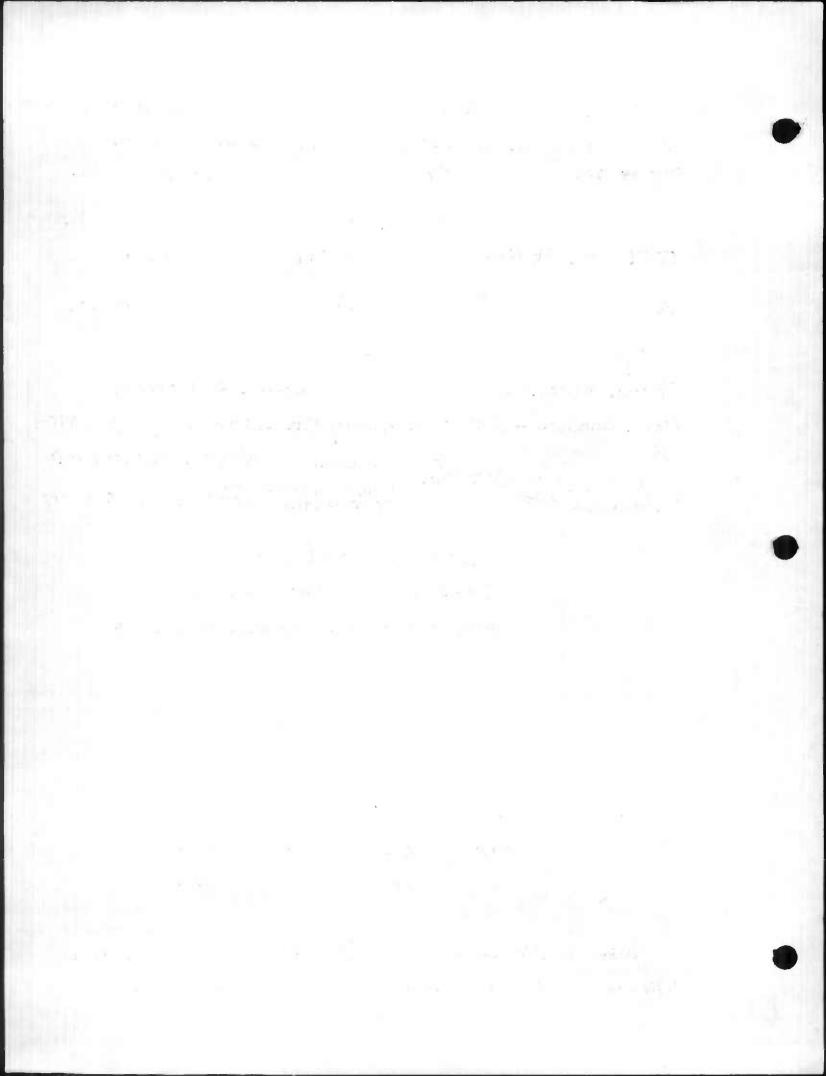
(Check only one)

Medical

31. Dete filed (Month, Day, Year)

FORT WASHINGTON 32. Registrar's Signeture

State 2 8 2000 Registrar



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** 9:49 AM NOVEMBER 24, 2000 WALTER AMERICUS BARNES /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALLIMORE SAINS ACNES HOSPIKAL H Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) South Soll of **Funeral** 1⊠M 2□ F 1932 Carolina 248-48-6029 68 November 6, Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. fnside Cltv Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Glen Burnie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 Hamlen Road 21061 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ № 950 — If Yes, Give Yeer or Dates: 1957 Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White À 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Truck Driver Trucking 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 88 Carroll A. Barnes Effie Justine Connley 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) New 27 I Mrs. Ann M. Caverly (Sister) 702 Hamlen Road, Glen Burnie, MD 21061 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State Date Pages 1 1 Buriel 2 Cremation 3 Removal from State 11-28-00 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Ctr 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Singleton Funeral Home, PA 1 Second Ave. S.W. Glen Burnie, MD 21061 AN or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximete Interval Between Onset and Death **Physician** >10 /Medical Immediate Cause (Finel YEARS disease or condition resulting in death) ACHEROSCLEROTIC CORONALY VASCULAR Examiner Due to (or as a consequenca of): Examine physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): of Vital Records, P.O. Box 68760, certificate be Physician/Medical that initiated events resulting in death) Last Due to (or es a consequenca of): SE USB ed by the a 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown BASIVAR ARIERY ANEURYSM: signed t by 24b. Were autopsy findings eveilable prior to 24a. Was en eutopsy performed? Completed LEFT THALAMIC AND OCCIPITAL LOBE INFARITS: completion of cause of death? certificate has t irector, paga 2 s 25. Was case referred to medical examiner? 1 Wes 2 No Hospital: 1 Inpatient 2 P 1 Yes 219 No 2□ No Be 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Dete of Injury (Month, Day Year) 27. Mannel of Death 1 Matural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 4 Homicide ò Hospital 24 hours Funeral 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and plece, and due to the cause(s) and manner stated. (Check only one) Within 2. To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OVENSY 27, 2000 cream MS - AKENDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KERNAN DRIVE. BALLIMORE 2200

32. Registrer's Signeture

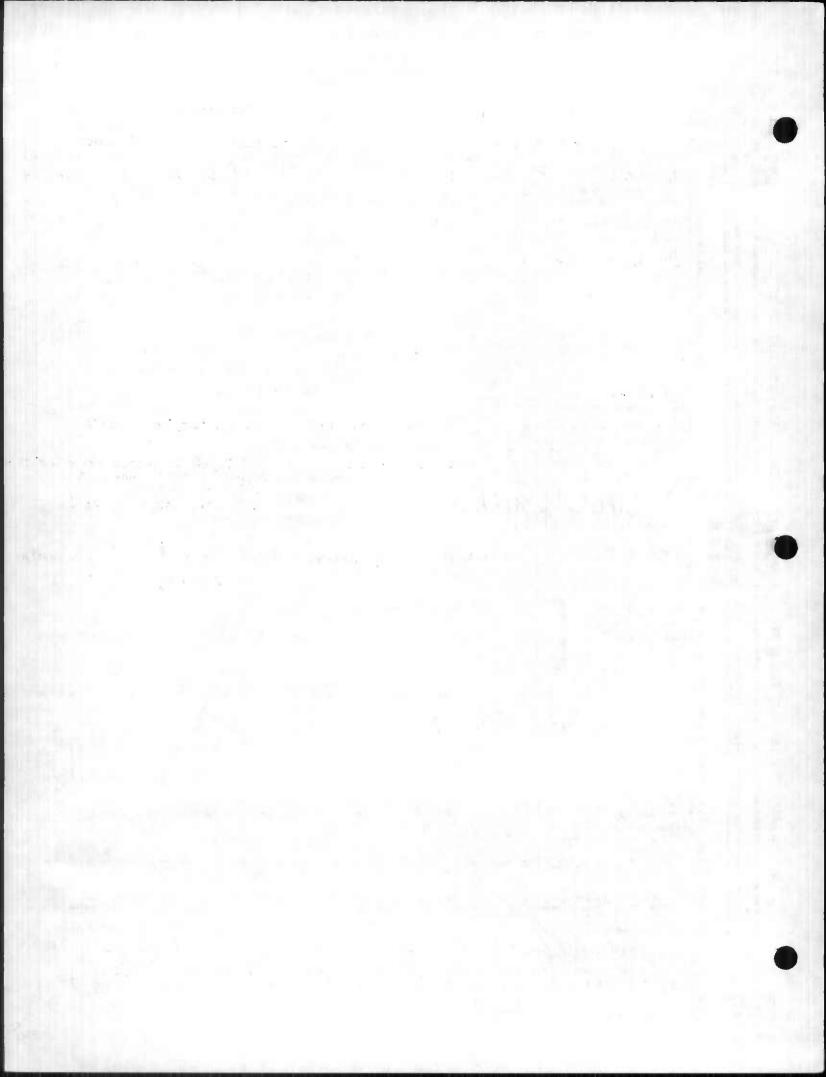
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31. Date filed (Month, Day, Year) NOV 2 8 2

State Registrar MEN CONTRACTOR JUST CO. SEVER BUILD BUILDING TO THE I ATTEN IN MAN THE PARTY OF I DAME TO THE REAL OF FAMILY STATE and the second of the second o

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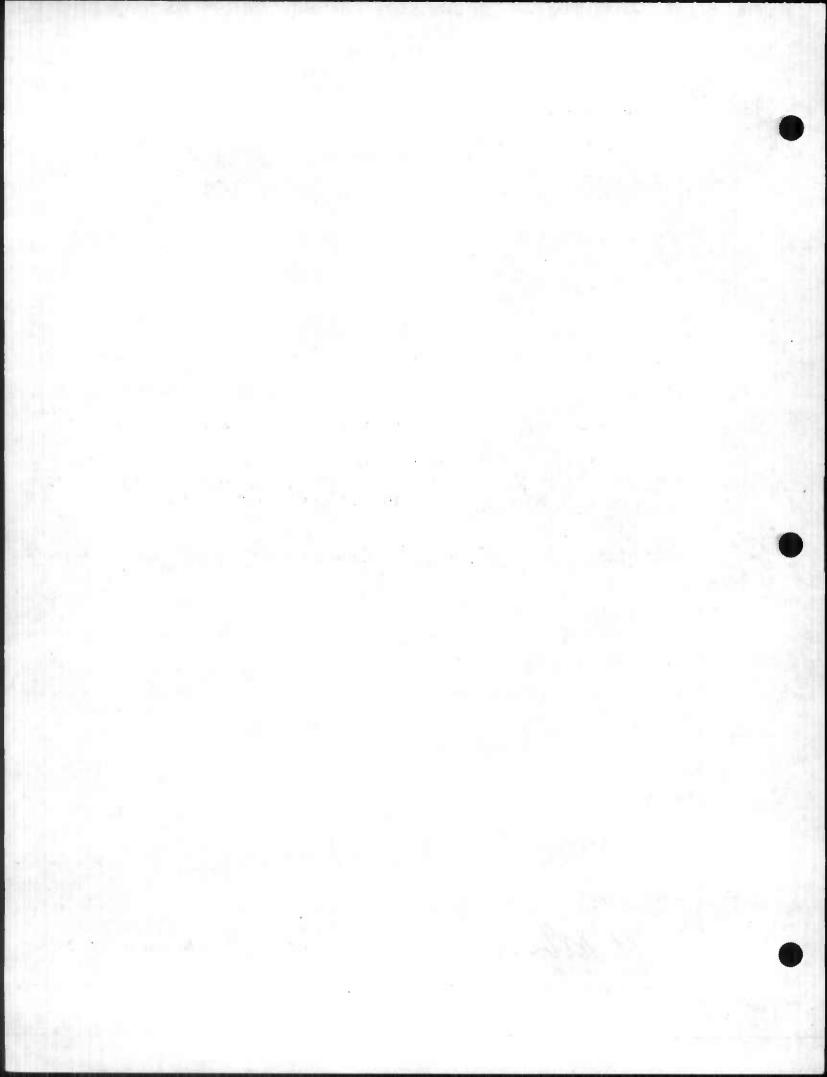
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7 28 Y	Director	10e. Sfreet and Num	ber		- 1	1	10f. Zip C	Code			10g. Citizen	of Whet Cou	intry?
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Mentel Mentel	To Be	Robert Bea	a m						Callie H	nohes			
M M M	F	19a. Informant's Nar		me Print)		19b Mailin	ng Address (		and Number or Ru		er. City or To	wn. State. Zi	in Code)
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State of Maryland / Department of Health and Mental Hygiene 0 37478

			Ce	illiouto o	f Death			Reg. No.		
	1. Decedent's Neme (First, Middle, L	ast)					2. Date of De Month	Dev	Year	3. Tima ol Death
ian ical	Lewis Alle	n Bell, Sr					Nov.	23, 20	000	1:15am
	4e Facility Name (If not institution, g	ive street and number)			4b. City, To	wn, or Lo	cation of Death	4c. County	of Death	
	1759 Abbotsto		D. 94.		Balt	imo	re	N.F.		
		VIV. OFF	yrs. last birthday,	Months Day		24 Hrs. Min.	8. Dete of Bir (Month, Da 04-24	th y, Year)	9. Birthp	lace (State or Foreig etry)
	215-30-1909	68	Yrs.				04-24	4-32		MD
+	Usual Residence of Decedent  10a. Stete 10b. County	100	. City, Town or L	ocation					1	0d. Inside City Limits
6										1□Yes 2□No
Director	MD NA  10e. Street and Number		Baltim	ore 10f. Zip Code				10g. Citizen of \	Affact Cour	
									TYTIBL COUL	nry r
Funeral	1739 Abbotsto	12. Was Decedent Ever	n 110 112	212		inin? (Con	oifu Van on No	USA	e - Americ	en Indian,
Ē	11. Meritel Stetus  1 ☐ Never Married 2 ☐ Merried	Armed Forces?	110,3.	Wes Decedent of If Yes, specify Co	uban, Mexicer	n, Puerto I	Rican, etc.)	Blac	ck, White,	
Dy	3 Widowed 4 Divorced	1 ☐ Yes ★No If Yes, Give Year or Dates:		1□Yes 2♥N	lo Specity:			Specify	Bla	ale
	15. Decedent's 8		16a Dece	dent's Usuel Occ	cupation	_		16b. Kind of B		
Completed	(Specify only highest g	rade completed)	(Give	dent's Usuel Occ kind of work dor DO NOT use ret	ne during mos ired)	t of worki	ng			
E C	Elementary/Secondary (0-12)  12th Grade	College (1-4or 5+) NA	Betl	hlehem	Steel			Shop	Stew	art
Sec	17. Father's Neme (First, Middle, Las				1		(First, Middle,	Maiden Suman		42.0
0	Lawrence	Bell, Sr.			Mol	lie		Stoke	s	
	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stre	et and Numb	er or Rura	I Route Numb	er, City or Town,	State, Zip	Code) 2123
	Lewis Bell,	Jr.		8 E. Ba						
1	20a. Method of Disposition		b. Place of Disp	osition (Name of			Date	20c. Location		
	A Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Spec	Removal from State		l Mem.		nsil	11-29-	2000 D	unda	lk, MD
1	21. Signature of Funeral Service Lice			2. Name and Add						
	DR mal O	roke -		M.C.Ma					_	nd 21202
+	23a Part I Enter the disease or an	Anications that caused the	1						AVE	Approximate
	23a. Pert1. Enter the disease, or or shock, or heart failure. List on	one cause on each line.	Journ. Do not of	nor the mode of c	lywig, odor oo	0410.40	. roopo.r, o			Interval Between Onset and Death
	Immediate Cause (Final	71	+							2 works
	disease or condition resulting in death)	a		Can	cev			1000	1	of hours
5		Due	to (or as a conse	quence of):						
CXamille	Constraint the time and this are	b	to (or as a conse	anence of).					1	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	500	10 (01 43 4 001130	quonos oi).						
COICE	thet mitteted events	CDue 1	o (or as a conse	quenca of):						
20 1	resulting in death) Last									
2		d								
SCI	Pert II. Other significant conditions	contributing to death but not	resulting in the	underlying ceuse	given in Pert	1.	23b. Dld	tobacco use co	entributs t	o the cause of death
Physician							10	Yes 2 No	3 Pro	bably 4 Unknow
þ						_				
								an autopsy	av	ere eutopsy findings allable prior to
									of	mpletion of cause death?
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Didina									1	
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	25. Wes case reterred to medical examiner?  1 □ Yes 2 ⅓ No	Hospitel: 1 Inpatient	2 ☐ ER/Outpatie	ent 3 DOA	Othor		me 5 Resi	one) idence 6 □Ott	ner (Speci	(v)
	examiner? 1 Yes 2 No 27. Manner of Death	1 L Inpatient 28a. Date of Injury	28b. Time	INT 3LI DOA	Other: 4 N	ursing Ho	me 513 Resi		-	(y)
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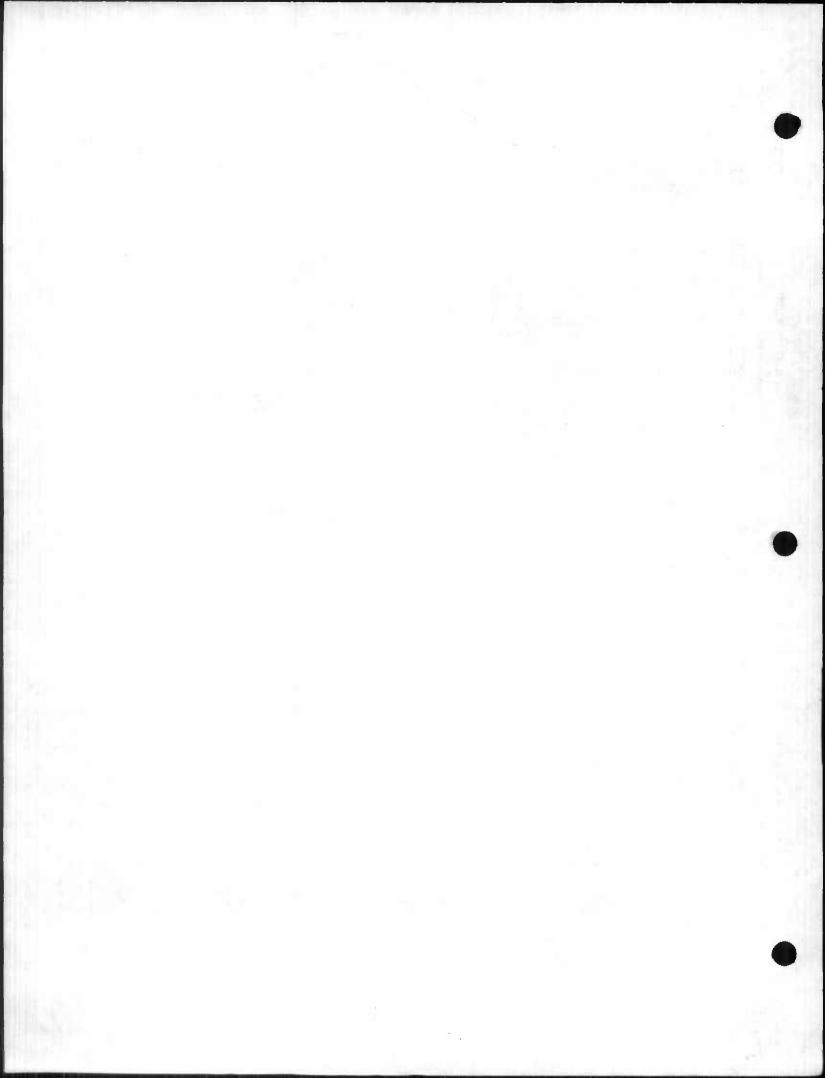
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Day Year **Physician** 3:16 PM rthur 8 VOV 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Hunder 24 Hrs. 8. Data of Birth Hours Min. Feb 28, General Howard Hospita Howard If Under 1 Year 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Months Days 219-26-1277 60 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Herne 23a or 28a-f abov the Maryt MD Howard Columbia 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene, sther than "natural", or hams 23e or ent, the Medical Examiner must be 6923 Catwing Court 21045 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 M Yas 2 □ No If Yes, Give Yaar or Dates: 160-63 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: black Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 janitor self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 8 and Mental Arthur A. Cole Sr Doris Parron 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s mant of Health an ä Department of Health a Important: If Item 27 is any injury or other treat 20.5s. Charlene Gross/spouse 6923 Catwing Court Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21 Signature of Fundad Service Licensee Ronald S. Wade, Director State and Affactomy ac Board 655 W. Baltimore Street nun 655 W. Baltimore Street Baltimore, MD 21201 Jacol 23a. Part. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Final disaasa or condition resulting In death) /Medical Adenocarcinoma Examiner Due to (or as a consequence of) Physician/Medical Examiner as the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disease or Injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. ate has been signed by the attending physician page 2 should be detached for use as the buria that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown g Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has 1 Yes 2 No 1 Tyes 2 Tho i or Attending Physician: after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? 1 Matural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 de Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signatura and Jitja of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2000 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Poblete Columbia MD Little 1055 106 31. Date filed (Month, Day, Year)

State Registrar

**DHMH 16 Rev 6/95** 

32. Registrar's Signature

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1445 PAUL CARTER 12 NOV. 00 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death Hame Baltimore City last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of B ection Hospital and Birthplace (State or Foreign Country) 6 Set 2DF 7. Age (In yrs. last birthday) Months Days Hours Min. Yrs. 53 213-52-8977 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 S. Charles Street 21230 14. Rece - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1∑ Never Married 2 Merried 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk College (1-4or 5+) Elementery/Secondary (0-12) carpenter 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) George Carter Virginia Mason 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Deaton Hospital and Home 611 S. Charles Street Baltimore, MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) In State 21. Signature of Funeral Service Licensee Royald S. Wade Director 22. Name and Address of Facility Board 655 W. Baltimore Street 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock or heart feilure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) . Multiple corebral abscosses 3months Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown IV drug abuse 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. ■Inpatient 2 □ ER/Outpatlent 3 □ DOA 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

by

**Funeral** 

**Director** 

Nem 27 is marked other than "natural", or items 23a or 28a-f ahow other traumetic event, the Medical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer a Department of health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the susception of the page.

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physicien and s the burial-trans 88 950 director,

Examiner or Attending Physician: after deeth. Director: After this certific funeral

P.O. Box 68760 Physician/Medical þ Division of Vital Records. Completed Be To Certification:

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

D 34974

State Registrar

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29b. Signeture end title of cartifier

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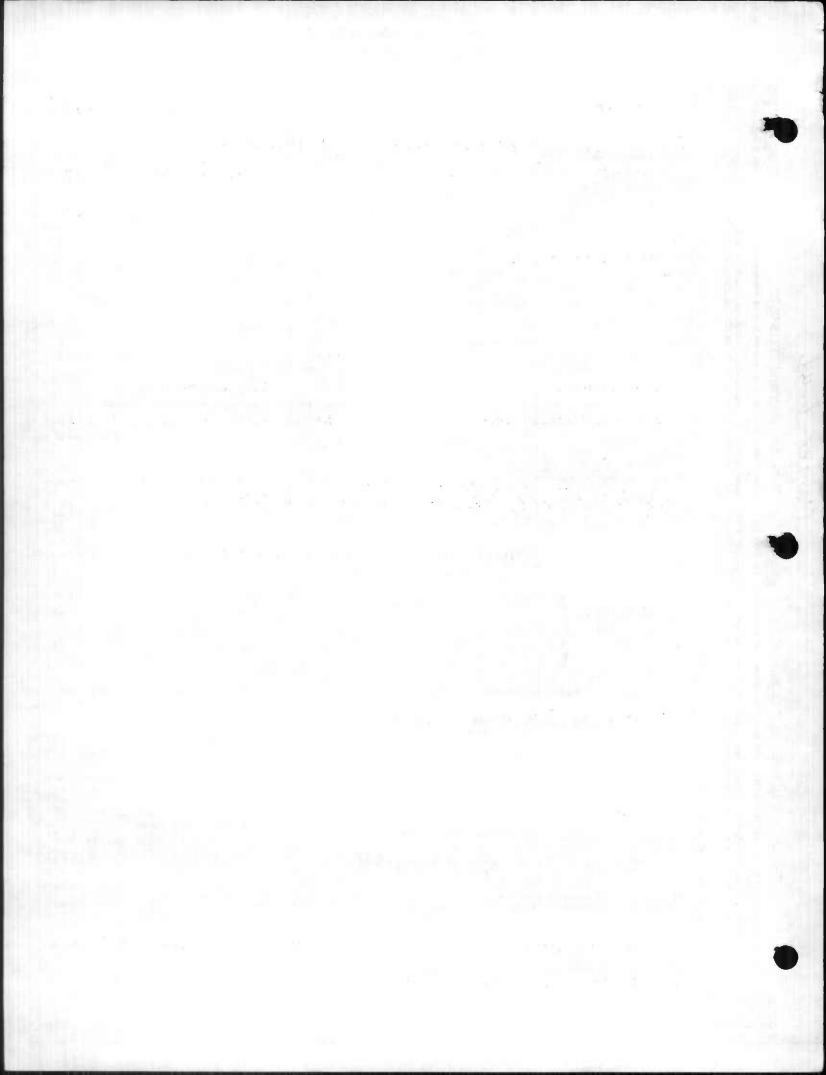
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
(HARN MEHTA, M) 611, South charles st, Baltimore, MD 21045

29d. Date signed (Month, Day, Year) Nov. 13th 2000

31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 28 2000 boarks

Hospital 24 hours a Funeral C

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## Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** PATRICIA CANDELORO 0456 11 27 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Johns Hopkins Bayview Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Months Days Hours Min Yrs. 214-38-8770 57 Director Nov 14, 1943 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 3701 North Point Road, Lot 20 21222 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☒ No Specify: ρÃ 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be and Mental is marked Evan Johnson Ethel Marie Fowler 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is it Yvonne Michelle Candeloro 3701 North Point Road, Lot 12, Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 12/1/00 Baltimore, Maryland Other (Specify) Loudon Park Cemetery of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Multiorgan 4 40 Examiner Due to (or as a consequence of): 6 hrs Physician/Medical Examin Hypoxia the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to completion of cause of death? should t 24a. Was an autopsy performed? Completed certificate has lirector, page 2: 1 ☐ Yes 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; I Be 25. Was case reterred to medical 26. Plece of Death (Check only one) Hospital: 1 Yes 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Nepatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: Watural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide **Decrifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

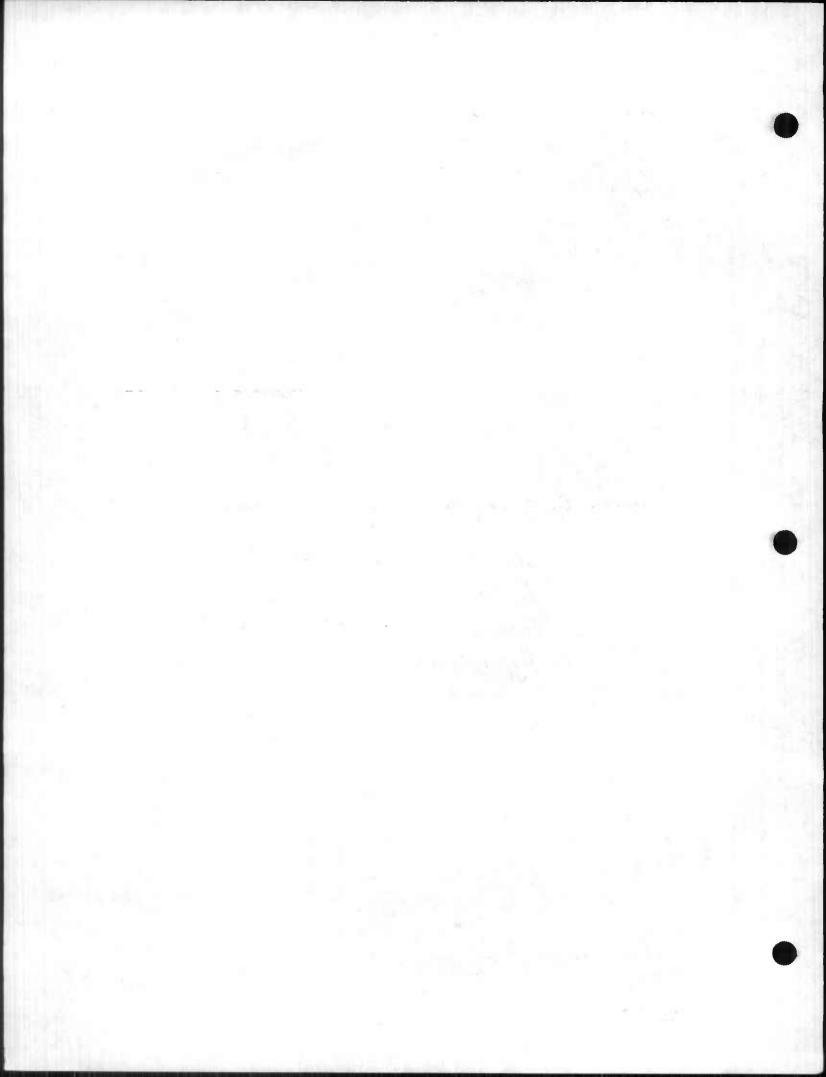
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. edicai 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 November 27,2000 RESTOELT 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) PHIL NIVATEUMIN, 600 N, WOLFEST, NELSON LOG, BALTIMONE, MOZIZET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 2 8 2000 ports

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Director	10e. Street and Number			10f. Zi	p Code			10g. Citizen of V	Vhat Countr	y?
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	19a, Informant's Name/Relationship		19b. Mai	ling Addres	s (Street e	nd Number or Ru	ıral Route Numbe	er, City or Town,	Stete, Zip (	Code)
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4	resulting In death) Last	Hyperx	lension	)					1	
sician	Pert II. Other significant conditions	contributing to death but	not resulting in the	underfying	cause give	n in Part 1.	23b. Did	tobacco use cor	ntribute to	the cause of death?
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Completed by Physic							24a. Was	an autopsy med?	ava	e autopsy findings lable prior to pletion of cause eath?
age 2							10	Yes 2 No	1 🗆	Yes 2□ No
	25. Was case referred to medical					26. Place of De	ath (Check only o			
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State of Maryland / Department of Health and Mental Hygiene 0 0 37483

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Examiner	4a Facility Name (If not institution, give stre			b. City, Town, or Loc	cation of Death	-	2000
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Funeral Director	220-05-2055	7. Age (In yrs. last	t birthdey) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) Dec 2	h v, Year) 1, 1924	Birthplace (Stete or Foreign Country)     Virginia
8	Usuel Residence of Decedent  10a. State 10b. County	10c. City. 7	Town or Location				10d. Inside City Limits
laho ada				ant City			1 ☐ Yes X ☐ No
vim the Ma t or 28a-t s be notified	Maryland Howar	<u>u</u>	10f. Zip Code	cott City		10g. Citizen of W	het Country?
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21215-0020 d within 72 hours after do general rest has headed Exerciner in the Medical Exerciner in Computation by Furna	11. Meritel Stetus 12.  1 Never Married 2 Married 3 Widowed 4 Ovorced	Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spe n, Mexicen, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race Bleck Specify:	- American Indian, White, etc. White
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Maryland d 2 should be file th and Mental Hy 7 is marked oth resumatic event	19e. Informant's Name/Relationship (Type,	Print)	19b. Mailing Address (Street a				
- 5 - 5 - 5	Mrs. Linda F		707 Fern Valley	Circle Apt. 1			
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1111	30. Neme and address of person who comp	leted ceuse of death (Item 23	3a) (Type, Print) MAI	-CHI A		EN, MI	1, tech
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State Registrar	NOV 2 8 2000 Sens	32. Registrar's Signatur	back				



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	15. Decedent's			16a.	Dece (Give	edent's Usua e kind of wor	al Occurring done	upation e during mos ed)	st of worl	king	16b. F		usiness/Ind		
lemantary/Secon	ndary (0-12)	Collega (		+)	_	ivate		d)			Uni	ted	Sta	tes A	Army
Fathar's Nama (/	First, Middle, La	ist)						18. Moth	er's Nam	ne (First, Middle,	, Maider	n Suman	10)		
Alex	C	lemons		THE TO				Ste	ella	i	На	a11m	on		
a. Informant's Na										ral Route Numbe					
Aretha	Cl	emons		2	.009	9 Eas	st i	30th	Str	reet Ba	ılti	Lmor	e, M	laryla	and
Method of Disposition 12 C	osition  Cramation 3 5 Other (Spec	3 □Removat from ecify)	State		ry, cran	matory or of	other pla	st VA	A Ce	Date			City or To		MD. Mill
Signature of Fun	eral Sarvice Lic	xensee War	ne	5				ress of Facilit	Da	altimor 1101 E.			-		202
shock, or heart	rt tailure. List on	omplications that only one cause on a	caused the	he daath. Do n	not ent	er the mode	e ot dyir	ng, such as	cardiac	or respiratory ar	rrast,		1	Approximate Intervat Bette Onset and I	ween
nediate Cause (F ease or condition ulting in death)		a Puli		ary Em				0.00					3	OMinu	ites
		- Myo	car	dial I	nf	arcti	ion								
quentially list con- ny, taading to imruse. Enter Under use (Disease or in	madiate rlying injury	С.		Due to (or as a c											
t initiated events ulting in death) La		d	D	Due to (or as a c	peanos	(uence of):									
	icant conditions		1 1		11							o use co			

**Physician** /Medical **Examiner** 

Department of Health and Mental Hygiene.
Important if them 27 is marked other than "natural", or items 25a or 28a-f ahow any injury or other treumatic event, the Medical Exeminer must be notified at 2008.

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Completed by Be Certification: To

The law requires that the death certificate be executed

To the Hospital or Attanding Physician:

Division of Vital Records, P.O. Box 68760,

Sequentiallif any, taadi cause. Ent Cause (Distribution that initiated resulting in

1. Deceden

4a Facility

Balti 5 Social Se

250-1 10e. Stata

> MD 10e. Street 2009

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Immediate disease or resulting in

Ale 19a. Intorn

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** Director

with the Marylar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case reterred to medical examiner? Hospital: 1 X inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 27. Mannar of Death 28b. Time of Injury

1 Natural 2 Accident 5 Pending invastigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 - Homicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed?

1 Yes 2 □ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and mannar as stated.
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) 29d. Data signed (Month, Day, Year) 29c. License number

26. Place of Death (Check only ona)

1 Yes 20 No 3 Probably 4 Unknown

24b. Wara autopsy findings available prior to completion of cause of death?

1 ☐ Yas 2 ☐ No

Physica Kesiden 30. Name and address of person who completed cabsa of death (Item 23a) (Type, Print)

Baltimore VA Hospital, 10 N. Greene ST. Ronald J. Pol 31. Date tited (Month, Day, Year) Polinsky Jr. M.D. 32. Registrar's Signature

State Registrar

Medical

29a. Certifier

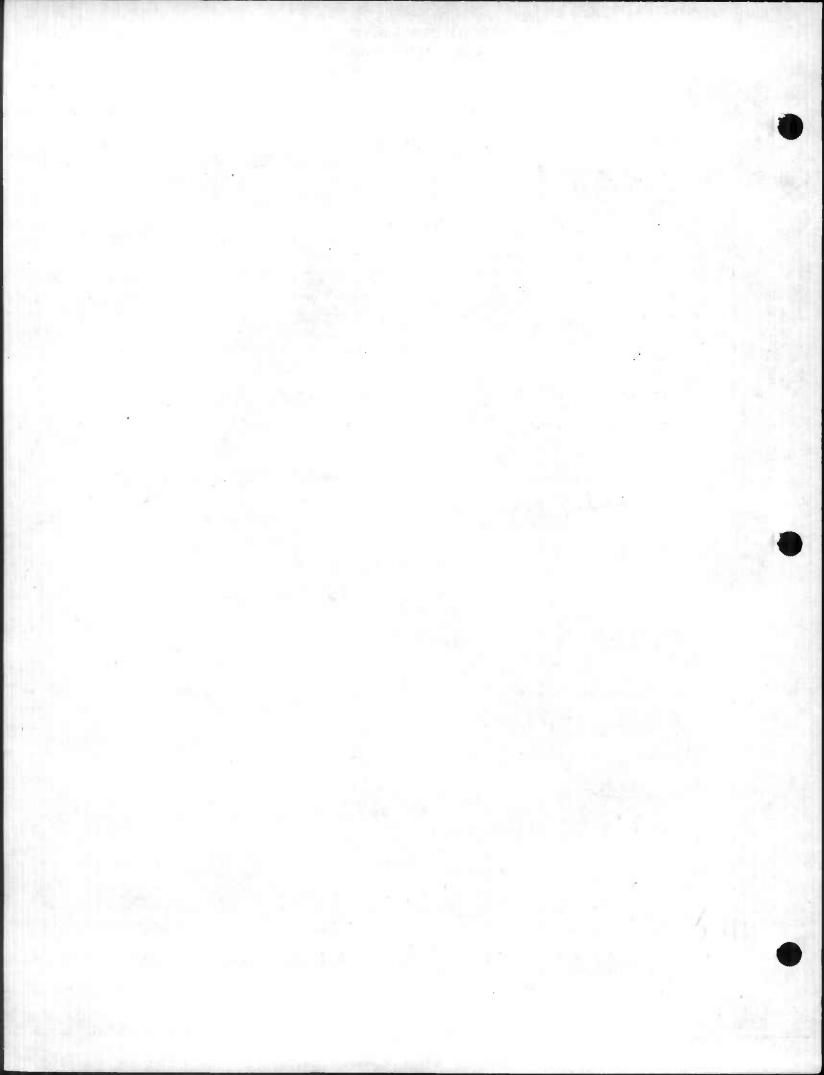
29b. Signature and 4ttle of

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	Please		Maryland / D	Indelible Inlepartment of Certificate of	Health and I	Mental Hy		3 7	485
Discolation.	1. Decedent's Nama (First, Middle, I	ast)	A Property			2. Date of De	eath Day	Year	3. Time of Death
Physician /Medical	ALBER	T		COHEN		NOVEME	BER 25,	2000	12:25 PM
Examiner	4a Facility Name (If not institution, g				4b. City, Town, or BALTIM			y of Death TIMOR	Œ
Funeral Director	5. Social Security Number 6. 216–10–2069	Sex 7	Aga (In yrs. last birtl 89 Y	ndey) If Under 1 Yes Months Day		8. Date of Bird (Month, De JUL 25	th y, Year) 1,1911	9. Birthp Coun	laca (Stete or Foraign try) MD
2 .	Usual Residence of Decedent		10c. City, Town	or Leastion				4.	Od toolds Ob. I imits
death with the Maryla rms 23a or 28e-f shor ir must be notified at theral Director	MD BALTI	MORE		FIMORE	36. (1)				0d. Inside City Limits 1 ☐ Yas 2 🛣 No
or 28e-f s be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
ath w	7218 PARK HEIGH				21208		U.S.A		
2 2 2 2		12. Was Decede Armed Force 17 Yes 2[ If Yes, Give Year or Date	s?  No ARMY	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N		pecify Yes or No o Rican, etc.)	Specif	ca - Amaric ick, White, fy: WH	
hour hour bed bed b				Decedent's Usual Occ	upation		16b. Kind of B	Rusinass/Inc	fustry
ed within 72 hours at vyglene, vr than 'netural', or it, the Medical Exam Completed by I	(Specify only highest g	rade completed) College (1-4c		Give kind of work don life. DO NOT use reti	e during most of wor	king	TOD. KING OF E	703110331110	iosity
		2	BOX	OKKEEPER					NMENT
Mental Hy whental Hy arked offin afte event	17. Father's Name (First, Middle, Las EPHRAIM	st)	COHI	EN	18. Mother's Nar		, Malden Sumei		ROBERG
d 2 shou th and M 7 is marry traument	19a. Informant's Name/Relationship	(Type, Print)		Meiling Address (Stre					
- E 8 5 5		BROTHER	-	34 PRINCE	GEORGE ROA				
Pages 1 hant of Hs oft: If liber ry or oth	20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Control of the Contr		te	Disposition (Nema of cremetory or other p FILOH CEME		Date 1/27/00	20c. Location		
Departm Departm Importan any Injur	21. Signature of Feneral Service Lice		DBIN 1	22. Name and Add		SOL LEV			
Certificate be associated and individual physician and oding physicien and as the burial-transit as as the burial-transit and individual Examiner	Immediata Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or Injury that initiated events resulting in death) Lasi	a. BL	Due to (or as a co	onsequenca of):  STAS 65  onsequenca of):	To 1	WITH			Onset and Death
death certification of attending at lor use as		d							
the dy	Part II. Other significant conditions	contributing to death	but not resulting In	the underlying cause	given in Part I.		tobacco use co Yes 2□ No	3 Pro	the cause of death
aw requir							s an autopsy ormed?	av	ere autopsy findings ailable prior to impletion of causa death?
in The I						10	Yes 20 No	10	Yes 2121No
Physicien: 1 this certifical ral director, p	25. Was case referred to medical examiner?	Hospital:			Whor	eth (Check only			
Fig. F	1 Yes 2 No	1 □ Inpe		patient 3LI DOA	4 AU Nursing P	lome 5 ☐ Resi 28d. Describe	how injury occu		V)
Attending or deeth.  ctor: After by the fune	1 Netural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	(Month, i	Dey Year) In	jury W	Yes 2 No				
- 222c E	3 Suicide 6 Could not determine	d 266. Placa of	Injury - At home, fan etc. (Specify)	m, street, factory, offic	a	28f. Location ( City or To	wn, Stete)	eper or Rure	el Route Number,
To the Hospital or within 24 hours after 10 hr. Funeral Direction of the comparison			of examination and	death occurred at the or investigation, in my					
Milhim Mal	29b. Signature and title of certifier	100.	0,0,0		anse number		29d. Data sign	ed (Month,	Day, Year)
sk.	Jasuau 30. Name and address of person wh TAS NBEM	o completed cause o	death (Item 23a) (I	Type Print)	L.C :-	1 -	P	100	21208
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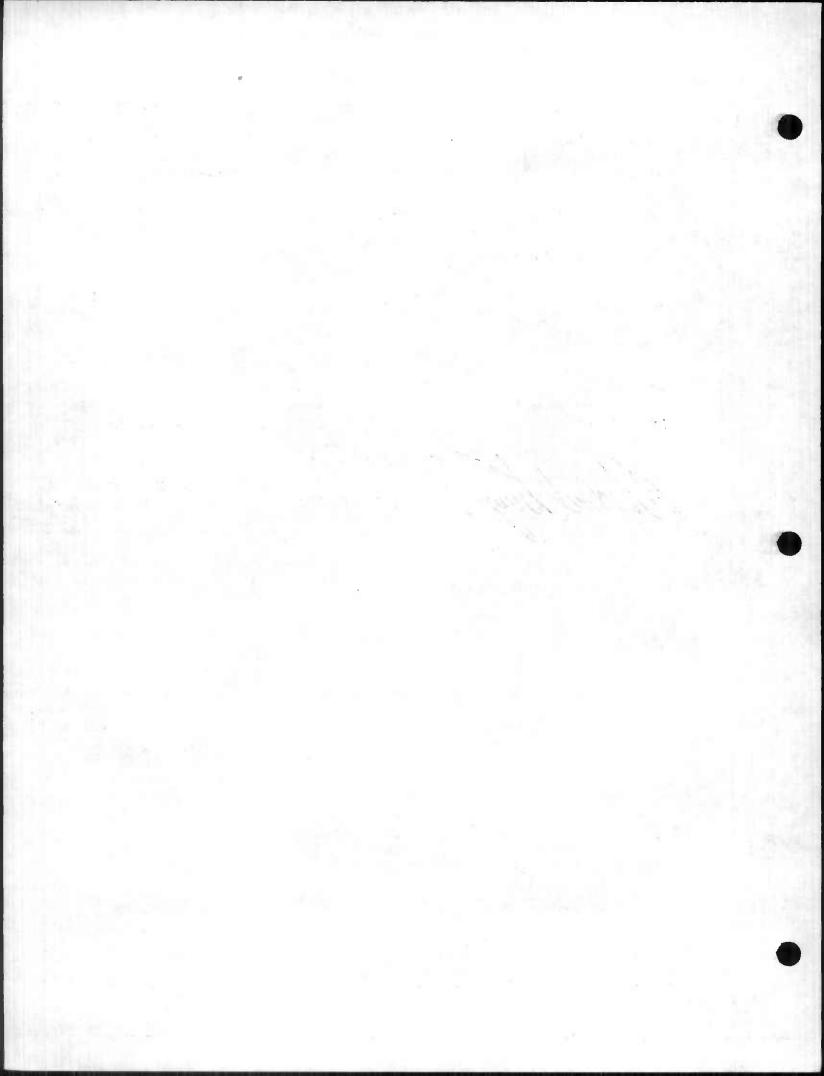
State Registrar 31. Data filed (Month, Pay, Year)

DHMH 16 Rev 6/95

32. Registrar's Signature

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ORIGINAL



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death Day Month **Physician** 12:08 AM Grace Sheridan Clark Novemberala 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Undar 24 Hrs. B. Baltimore Square Hospital ranklin Center 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar Birthplaca (Stata or Foraign Country) Data of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 ☐ M 2 🖾 F 74 Director 219-20-8930 March 1,1926 Maryland Usuat Rasidance of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Director Huntingdon Shade Gap 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? P. O. Box 148 17255 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Maritat Stetus Black, Whita, atc 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Never Merried 2 Married White 1 ☐ Yas 21 No Specify: Specify: py 3 XWidowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) Collega (1-4or 5+) Homemaker Own Home 18. Mother's Nama (First, Middle, Maiden Sumama) 17 Father's Nama (First Middle Last) Paul Brown Green Winifred Agnes Sheridan 19e. Interment's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Sarah N. Miller (Daughter) Rd#1, Box 297; Blairs Mills, PA 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Crametion 3 ☐ Ramovel from Stata Finksburg, Maryland 4 Donation 5 □ Othar (Specify) Sandymount Pleasant Grove 11/29/00 22. Nama and Addrass of Facility Loring Byers Funeral Directors, Inc. 21. Sign atum bi Funeral Service Licenses 8728 Liberty Road; Randallstown, Maryland 21133 23. Pent 1. Entar life disease, or complications thet caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tellura. List only one ceuse on each line. Approximata Interval Between Onset and Deeth **Physician** Immediata Caysa, Finat diseese or condition rasulting in daath) /Medical 40 minutes Examiner Examiner Cardiovascula Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Lest Due to (or as a consequence ot): Physician/Medical Dua to (or as a consequence of) Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yas 2 No Be 25. Was casa ratarred to medical axaminar? 26. Place of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidenca 6 Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place ot tnjury - At home, tarm, street, factory, office building, atc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledga, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the 2

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Pages 1 and 2 should

or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

physicien s the burial

been signed by the a should be detached t

After this

24 hours after death.

Hospital

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State Registrar

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30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

29b. Signatura and titla of cartif

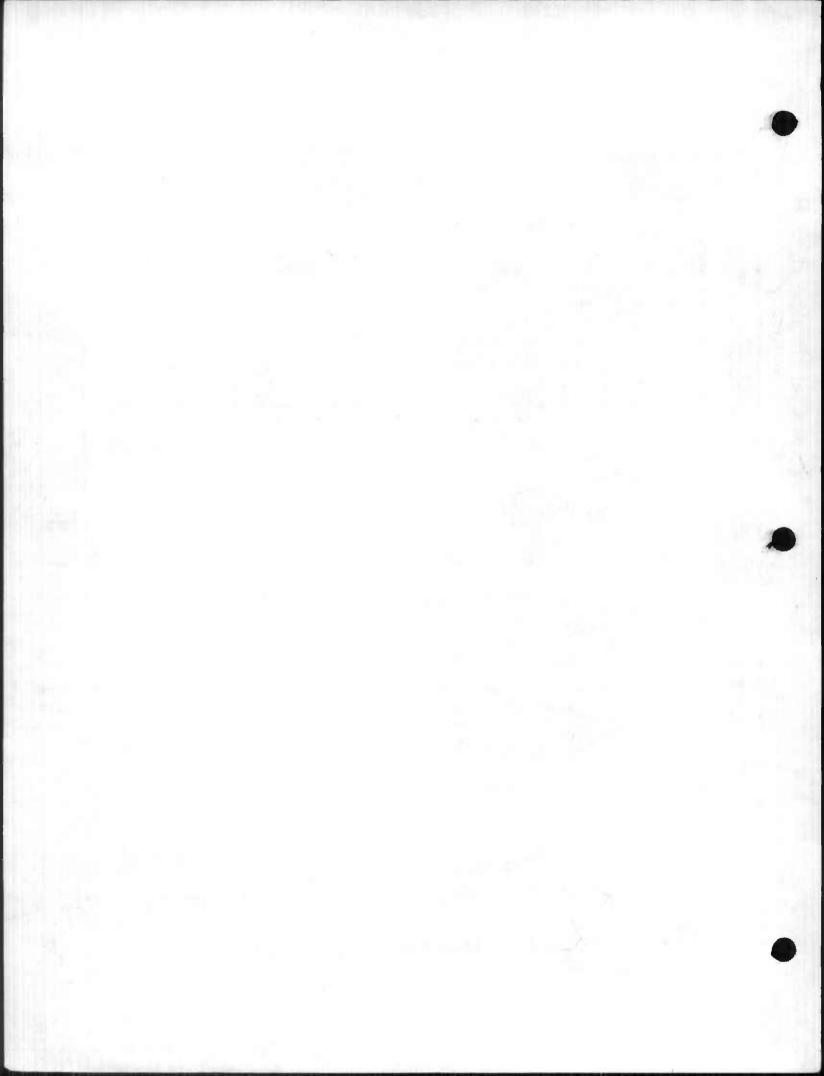
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Himore Maryland 21837 Drive

29c. Licensa number

29d. Data signed (Month, Day, Year)



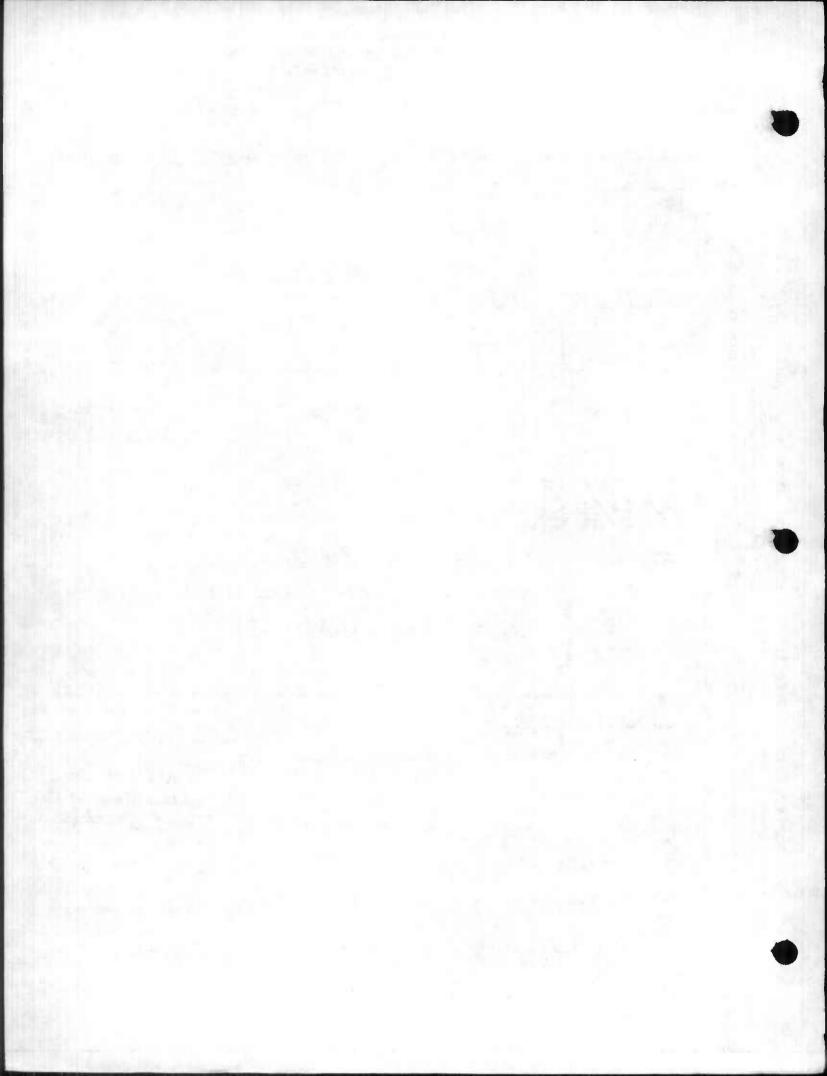
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State of Maryland / Department of Health and Mental Hygiene 0 3 7 4 8 7

		Certificate of Death	Reg. No.	01401			
Physician	Decedent's Name (First, Middle, Last)		2. Date of Death Month , Dey	3. Time of Death			
/Medica	VIVIAN LORENE CHILCUIT		NOVEMBER 20, 2000 (				
Examine			ty, Town, or Location of Death 4c. County of Death				
	STELLA MARIS @ MERCY	BALTIMO  oirthday) If Under 1 Yeer   If Under 24 Hrs.	/				
Funeral Director	5. Social Security Number  5. Social Security Number  6. Sex  1 M 2 K F  7. Age (In yrs. last b)  1 Usual Residence of Decedent	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year) SEPT. 11, 192	9. Birthplace (State or Foreign Country) 25 MISSOURI			
B 8 w		wn or Location		10d. Inside City Limits			
Mary Hath	MD. BALTIMORE LOC	CH RAVEN		1 ☐ Yes 2 No			
D with the Ma 23s or 25s-f s unt be notified	10e. Street and Number 1344 DARTMOUTH AVE.	10f. Zip Code 21234	10g. Citizen of Wr	net Country?			
21215-0020 d within 72 hours after deatlines. r than 'natural, or items the Medical Examiner mu	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		American Indian, White, etc.			
22 ho		a. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Bus	iness/industry			
21	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		TNCIDANCE			
0 5 9 4 6	Elementary/Secondary (0-12) College (1-4or 5+)	SECRETARY					
S 2 2 2 2 2			18. Mother's Name (First, Middle, Maiden Surneme) GRACRTE MOMBERG				
Baltimore, Mar permit. Pages 1 and 2 sho Department of Health and Important: If them 27 is ma any injury or other traum bace.		2b. Meiling Address (Street and Number or Rur 213 FAIROAKS AVE.,					
	20a. Method of Disposition  1 Buriel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)	of Disposition (Name of ery, cremetory or other place) MORE WASHINGTON		ity or Town, State			
	21. Signature of Funeral Service Licenses	22. Name and Address of Fecility CHARLES S. ZEILI 6224 EASTERN AVI	1/22/00 LAURE ER & SON, INC				
	23a. Part 1. Enter the disease, or complications that caused the deeth. Do shock, or heart failure. List only one cause on each line.			, MD. 21224			
Care be executed by the principle of the	Cause (bisease or Injury that initiated events resulting in deeth) Last	tory Failure a consequence of: Drustwe Pulme a consequence of: Use Lung a consequence of:	enary Desia	Onset and Death			
The law requires that the death certaine has been signed by the attending page 2 should be detached for use	Part II. Other eignificant conditions contributing to death but not resulting	23b. Did tobacco use contribute to the cause of					
Vital Records, idean: The law requires t certificate has been signe rector, page 2 should be a constituted by the constitute of the consti	Hypertension		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
Vital Rec			1 □ Yes 2 No	1 ☐ Yes 2 ☐ No			
/ita	25. Was case referred to medical examiner?		h (Check only one)STE!/A	MARIS AT MERCY			
A SED F	1 Yes 2 No Hospital: 1 Inpatient 2 ER/C		ome 5 Residence 6 Other	(Specify) HOSPICE			
Division or Attending Patier death. Director: After din by the funer	27. Manner of Death  1 Natural 5 Pending (Month, Dey Year)  2 Accident Investigation	Time of Injury at Work?  M 28c. Injury at Work?  1 Yes 2 No	28d. Describe how injury occurre	d			
Division of the form of the fo	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, offica	28f. Location (Street end Number City or Town, Stete)	r or Rural Route Number,			
Hospi 24 hou Funer tely fill		ge, death occurred at the time, date and place, ind/or investigation, in my opinion, death occur	and due to the cause(s) and man red et the time, date and place, ar	ner as stated. nd due to the cause(s)			
To the Tethe	29b. Signature and title of certifier	29c. License number	29c. License number 29d. Date signed (Month, Dey, Year)				
V	but his mo	D40853	NouEmb	ER 20,2000			
Sy	30. Name and address of person who completed cause of death (Item 23a)	) (Type, Print)	) A1 1	11			
State	DAVID KISEDERG 301-	ST PAUL P/ E	sallemore 1	10 2/202			

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. amend item per dvr G790 12/13/00 yf State of Maryland / Department of Health and Mental Hygiene Amendee Item#31 perDVRG789 11/28/2000 EW Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Noy 20 2000 Duvall R. Davis Sr /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** SAINET BALTIMORF HAMES HEALTHCARE If Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) 5. Social Security Numberunk 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1MM 2□ F Yrs. 579-36-4276 68 VA Director Usuel Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1X Yas 2 No Director 23s or 28s-f 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 21229 USA 5301 Brabant Road 12. Wes Decedent Ever in U,S. Apped Forces? 1 ☑ Yas 2 ☐ No If Yas, Giva Yeer or Detes: 14. Race - Amarican Indian, Black, White, etc. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 11. Meritel Stetus 1 Nevar Married 2 Married ö white Maryland 21215-0020 1 ☐ Yas 2 No Specify: 3 Widowed 4 Divorced 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elementary/Secondary (0-12) disabled none 18. Mothar's Nama (First, Middle, Maidan Surnama) UNK 17. Father's Nama (First, Middla, Last) merked of Duvall R. Davis 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 111 Penn Street Baltimore, MD O.C.M.E. Department of Health Important: If Item 27 Saltimore, 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Pages 1 Burial 2 Cramation 3 Removel from State
4 Donation 5 Othar (Specify) In State 8 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Name end Address of Facility
State Anatomy Board 655 W. Baltimore Street Director man Dule Baltimore, MD 21201 Enter the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediete Causa (Finel disaasa or condition resulting in death) /Medical 30 MIHUTES HeITY CHOLDIA EMTRICULLAR **Examiner** Due to (or as a consequence of): Physician/Medical Examine ARBIOWYOPA Sequentially list conditions, if eny, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last attending physician and IABETES MELLIT Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MELLITE Aq 24b. Were autopsy findings eveilable prior to complation of cause of death? 24a. Was an autopsy performed? Be Completed has 1 Tas 2 DNO 1 ☐ Yas 2 ☐ No After this certificate of Vital Physician: the funeral director, 25. Was casa refarred to medical 26. Placa of Death (Check only one) Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA Othar: 4☐ Nursing Homa 5☐ Rasidence 6 ☐ Othar (Specify) Medical Certification: To 1 Yas 2 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending invastigation Natural 1 Yas 2 No s after death 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signeture end titla of certifiar 29d. Dete signed (Month, Day, Year) 30. Name and addrass of person who completed causa of daeth (Itam 23a) (Type, Print) IHERSON KARL QUIST -

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year)

Daval

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: 5 PER F.H. G789 11-28-00 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year solember 00:40am 24 2000 - MMa 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Homere 4050ma Oncu (9. Birthplaca (State or Foreign Couptry) 7. Age (In yrs. lest birthdey) If Under 1 Yea If Under 8. Dete of Birth (Month, Day, Days Min. Hours Months 1□M 20 F 81 Yrs. 919 Isleoth **Usual Residence of Decedent** 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 280 21213 12. Was Decedant Evar In U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Merried 2 Merried 1□ Yes 20 No Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) ondery (0-12) College (1-4or 5+) tress 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middla, Last) CORGE DO mant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Ny MOOR -00 5+ONE 84.21239 Balto 20a. Memor of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 1 L/Burlel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 10 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Home 5 UNERA or complications the aused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, but only one cause of each line. 23a. Pert1. Enter the discordance, or heart tailure Approximete Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) 48 hous Due to (or es a consequence ot): Dua to (or as a consequence of). Dua to (or as a consequence ot): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wiknown 24b. Were eutopsy tindings available prior to completion of causa of death? 24e. Wes an autopsy performed? 2/2000 1 ☐ Yes 2000 1 TYaa 26. Piece of Deeth (Check only one) Hospitel: 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Mariant 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury at Work? 5 Pending investigation 1 Yas 2 No

Physicsen /Medical Examiner

ed by the attending physician and detached for use as the bunal-transit the death cartificate be axecuted

been signed behold be dete

page 2 should Completed

eral Director: After this certificate has illied in by the funeral director, page 2:

i or Attanding F

To the Hospital within 24 hours a To the Funeral Completaly filled

Examiner

Physician/Medical

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Certification: To

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permit. Pages 1 and 2 at Department of Health and Important: If Item 27 is in any injury or other traus obice.

**Physician** 

/Medical

Funeral Director

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Completed

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Examiner

Funeral

Director

s and Mental Hygiene. Is marked other than "natural", or fleme 23s or 28a-f show murretto event, the Medical Examinar must be notified at

the Maryland

72 hours after death with

Illed within

should be

Maryland 21215-0036

Baltimore,

Box 68760.

that

The law requires

of Vital

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case reterred to medical examiner?

Manner of Deeth

2 Accident 3 Suicide 6 Could not be determined 4 T Homicide

28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

295. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

noncy faul Pace Beltimera MD 32. Registrer's Signeture 31. Date filed

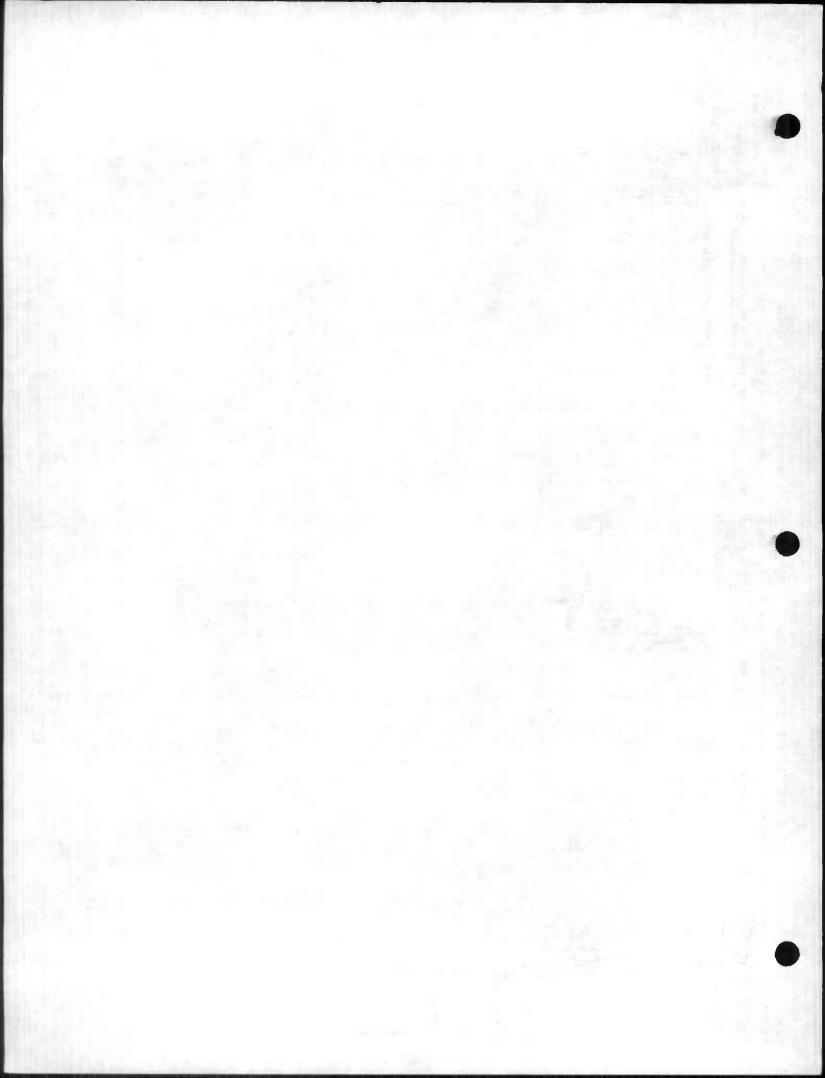
State Registrar

**DHMH 16 Rev 6/95** 

State of Ma

aryland / Department of Health and Mental Hygiene	00	37490
Certificate of Death Reg. No.		0,100

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Examiner	4e Facility Neme (If not institu	tion, give	street and numb	er)				4b. City, To	wn, or L	ocation of Deet	th 4c.	County of	Deeth	1944	
	Mariner Hea														
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r Her of	1 Never Merried 2 N	lerried	Armed Force 137 Yes 2 If Yes, Give	as?						Rican, etc.) Bleck, White, etc.					
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72 ho hastur lical	15. Deced	lent's Ed	ucation		16a. Decedent's Usual Occupation (Give kind of work done during most of working					cina	16b. K	ind of Busi	nass/Indust	ry	
ed within 72 ho yglene, wer than "natur it, the Medical Completed	Elementery/Secondary (0-12	-	Cottege (1-4	or 5+)	(Give kind of work done duning most of working life. DO NOT use retired)  Barber					ang.					
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Page At: III	1 ☑ Burial 2 ☐ Cramatic			ala		crematory or Cemet		ica)	1:	1/27/00	Mout	h of	Wilso	on, V	A
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Physician /Medical	7 shock, or heart failure. 1	ist only	one ceuse on eec	th line.									trit	ervel Betweenset end De	een eeth
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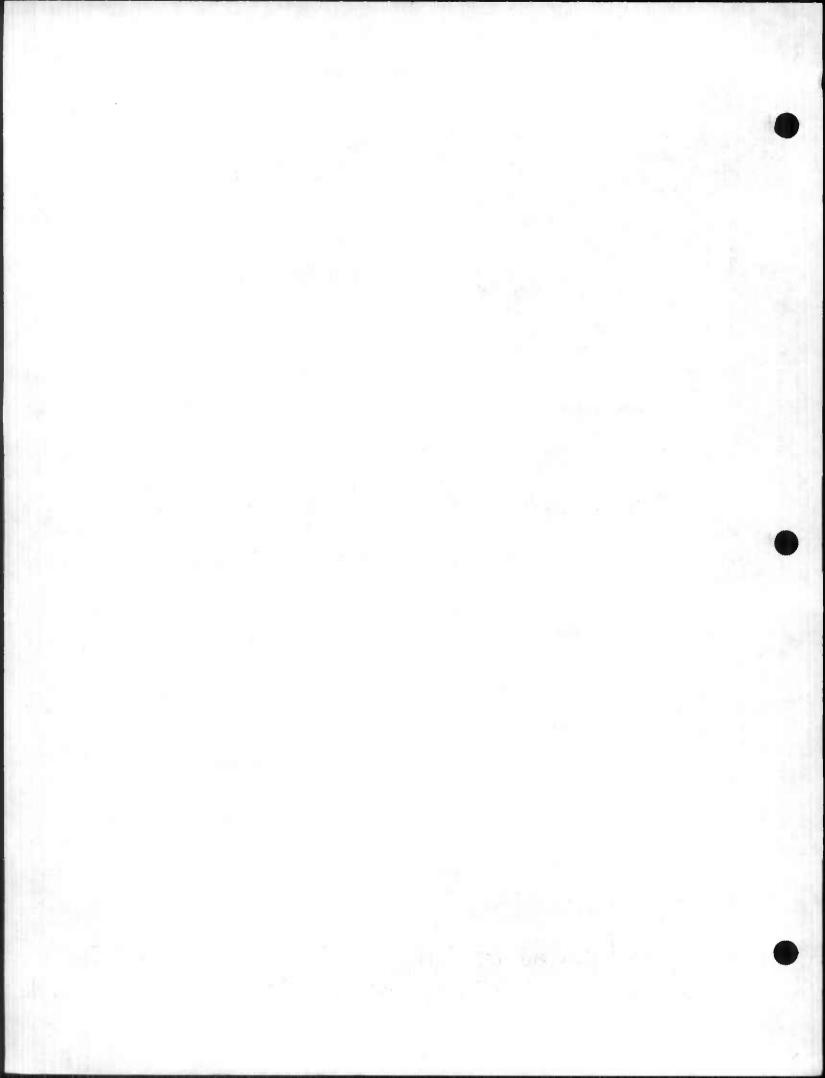
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Certificate of Death Reg. No.

					Cer	tificate	e of	Death			Reg. No.			
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21215-0020 d within 72 hours at piene. r than 'natural', or	of the Me	Elementary/Secondary (0-12)	College (1-4or	5+)	lite. [	OO NOT us	e retire	d)			Baltimo	altimore City		
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and 2 shot salth and A	ar trauma	19e. Informent's Name/Relationship (Type, Print)  Barbara McCarthy/ Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town 304 Community Road Severna Park, Mar												
Pages 1 ment of He ant: if iten	ury or offi	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		20b. Place cemen Most	ant aren	antoni or of	thar ale	er cem	eter	y 11/25	20c. Location Baltim	-	own, State Maryland	
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Physic /Med Exami	ner	shock, or heert failure. List only Immediate Cause (Final disease or condition resulting In death)	a. Alz	Due to (or as a	S conseq	der	ner	tha	- 5	Gevere		1	Interval Between Onset and Death	
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Ing Pl	uneral lon:	27. Manner of Death 1 12 Natural 5 ☐ Pending	28a. Dete of fnj (Month, De	ay Year) 28b.	Time of Injury		8c. Inju			28d. Describe	how injury occu	rred		
一 るもち	ed in by the funera Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined	28e. Place of tr	ijury - At home, tc. (Specify)	farm, str	M eet, factory		]Yes 2□	No	28f. Location ( City or To		ber or Rui	ral Route Number.	
Hospita 4 hours Funeral	Medical Ce		nysician: To the best miner: On the basis of and menner s	of examination a										
To the To the	Me Me	29b. Signature and title of certifier	MA TAX			290	. Licen	se number			29d. Date sign	ed (Month	, Day, Year)	
	0	30. Name and address of verson who	completed cause of	death (Item 23a	Type.	Print)		D50	77	28	Novem	here	12, 2000	
0.0	State	John F. Loome, 31. Dete filed (Month, Day, Year)	M.D. 47	9 Tury	vers.	fole	Zorio	1#3	,04	Seve	ma Pa	ck	MD 21146	
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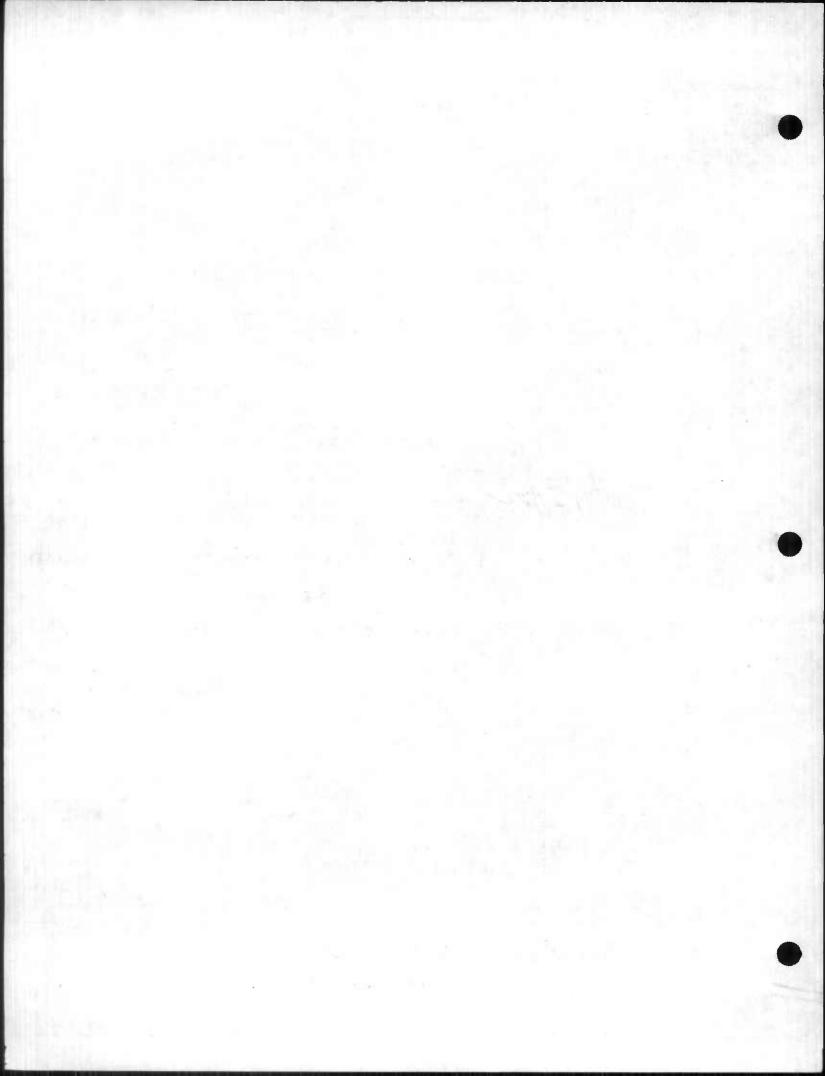
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State of Maryland / Department of Health and Mental Hygiene 0 371, 92

			Certificate of	Death	Re	g. No.	0 1	4 7 Km				
	1. Decedent's Nema (First, Middle, La				2. Dete of Death Month			3. Tima of Death				
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/Medical Examiner	4a Fecility Name (If not institution, giv	a street and number)		4b. City, Town, or L.		4c. County of	of Death					
	Cot	onsville Commons		Baltimor	e City	Ra	ltimore	City				
Funeral	5. Social Security Number 6. S	Sex 7. Age (In yrs. la	ast birthdey) If Under 1 Yea	If Undar 24 Hrs.	8. Dete of Birth (Month, Dey,			ce (Stete or Foreign				
Director	218-18-2377 X	□M 2□F 82	Yrs. Months Days	Hours Min.	Jan 1. 19		W.					
10	Usual Residence of Decedent	V-			Jan I, I	710	N.W.	уд.				
arytan ahow dat	10a. Stete 10b. County	10c. City	, Town or Location				10d	I. Inside City Limits				
a Ma liffed cto	Maryland How	vard	EII	icott City				1 □ Yes _X 2 □ No				
or 28er a	10e. Street and Number		10f. Zip Code		10	g. Citizen of WI	het Country	17				
5 March 111	4744 Woodland Rd.			21042		ι,ι	U.S.A.					
har death r hams 23 signs must Funeral	11. Meritel Status	12. Wes Decedent Ever In U.S Armed Forces?	S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp	ecify Yas or No-		- American					
S ahar or har mines	1 Never Merried 2 Merried	1 Yes 2 No	1 ☐ Yes № No		rioan, atc.,	Specify:						
Dy Est. 10	3☐ Widowed 4 ☐ Divorced	Year or Dates:	TIL 195 XIII	эрөспу.		te						
21215-0 ed within 72 ho spiece, we then 'nature it, the Medical Completed	15. Decedent's Ed (Specify only highest gre		16a. Decedent's Usuel Occu (Give kind of work done		ring 1	16b. Kind of Business/Industry						
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and do mile mile mile mile mile mile mile mile	17. Fathar's Name (First, Middle, Last)			18. Mother's Nem	e (First, Middle, M	e <i>iden Sum</i> eme	9)					
Via Menda Menda To	Cass B. I	Delawder			Minnie Bell							
Sah Sah	19a. Informant's Neme/Relationship (	Type, Print)	19b. Mailing Address (Street	et end Number or Rui	ral Route Number,	City or Town, S	Steta, Zip C	ode)				
Z 22 27 2	Ms. Rose	Fant	4744 Woodlan	d Rd. Ellicott C	ity, Maryland	21042						
or the state of th	20e. Method of Disposition	CO	ece of Disposition (Neme of emetery, cremetory or other pi	ece)	Dete 2	Oc. Location - C	City or Town	n, Stata				
Pages 1	1 ☐ Burial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		True Gospel Cem	etery 1	1/22/00	Lisbo	n, Maryl	and				
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68760 ficate be e physician is the burie	Cause. Enter underlying Ceuse (Disease or injury) that initiated events  Due to (or as a consequence of):											
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	27. Menner of Death 1 ☑ Netural 5 ☐ Pending	(Month, Dey Year)	28b. Time of Injury 28c. Injury W		28d. Describe ho	w injury occurre	ed					
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Division  or Attending after death. Director: After d in by the fune ertification	4 Homicide determined		me, farm, street, factory, office )		28f. Location (Str. City or Town	eet end Numbe , Stete)	er or Hurei i	Houte Number,				
Spital Ce												
To the Hospital	(Check only 2 Medical Exam	yelclan: To the best of my knowniner: On the basis of examineti	viedge, deeth occurred at tha ion and/or invastigetion, in my	time, dete end plece, opinion, deeth occur	end due to the ce red et the time, de	use(s) and mar te end plece, e	nner es stat and due to ti	led. he cause(s)				
1	one)	end menner steted.			-			Marant				
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1	30. Name and address of person who	1		Y 1	1 5	11	111					
10	Louis Mille	2 MD 18	138 Greene	Tree F	59 \$	a (10.	Md.	21205				
State	31. Date filed (Month, Dey, Year) NOV 2, 8, 2000	32. Registrer's Signet	ure									
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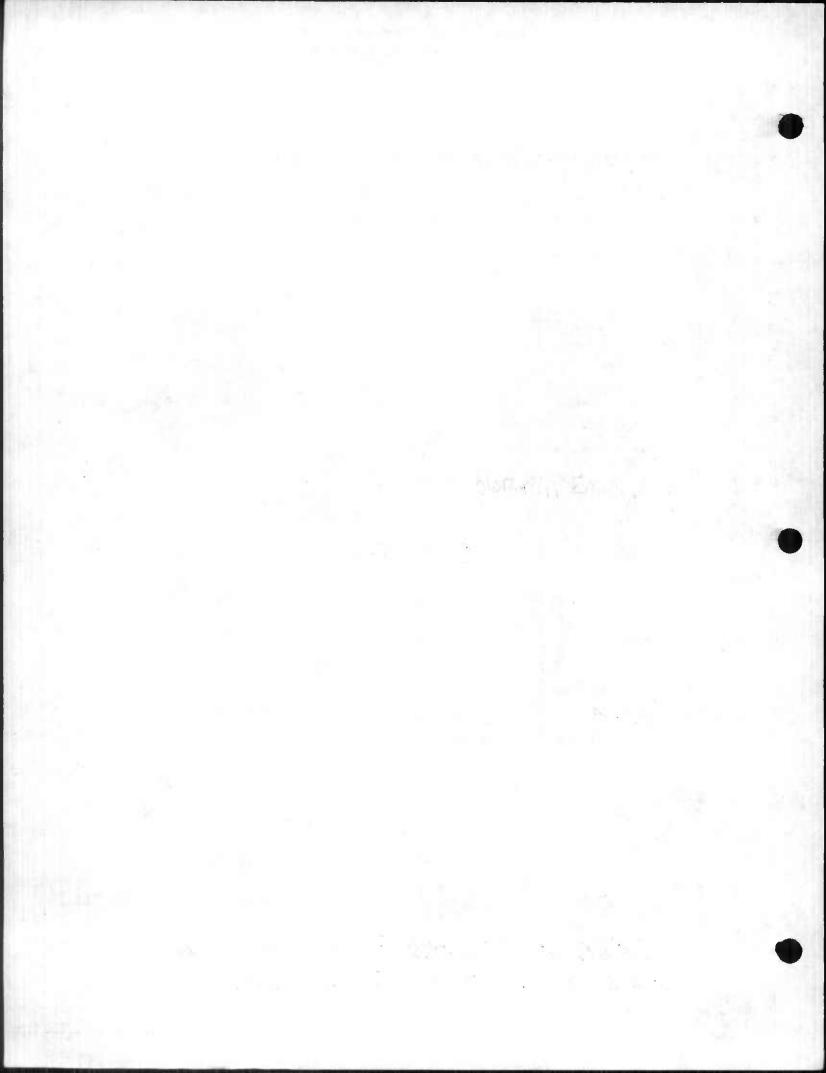
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend Item#4b perPHYG790 12/14/2000 EW Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Kimberly Ann Derflinger November 2000 3:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Pasandena Pasadena 1288 Magothy Road Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 218-90-1124 Yrs Director OCT 23, 1963 | Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes ¾☐ No Florida Charlotte Port Charlotte Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? finer must be n 5080 Condado Terrace 33981 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: À 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Day Care Provider Home Day Care is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H ant; If Nem 27 is marked off Be Phillip Derring Patricia Buckingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5080 Condado Terrace Port Charlotte, FI. 33981
ce of Disposition (Name of Dete 20c. Location - City or Town, State Dale W. Derflinger/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-27-00 Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Date of McDornal 22. Name and Address of Facility
Cremation Society of MD, Inc. 299 Frederick Road Baltimore. 21228 Approximate tnterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediate Cause (Final disease or condition resulting in death) 8 months Examiner Due to (or as a consequence of) Examine that the death certificate be executed physician and s the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): for use as aigned by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy tindings available prior to completion of ceuse of death? 24e. Was an autopsy parformed? Completed page 2 1 ☐ Yes 2 ☐ No certificate 25. Was cese reterred to medicel examiner? 86 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Residence Sister's 1□ Yes 20 No Hospitel: 10 1 Inpatient 2 ER/Outpatient 3 DOA Piss 28d. Describe how injury occurred 28a. Date of tnjury (Month, Dey Year) 28b. Time of tnjury 27. Manner of Death 28c. Injury at Work? Certification: 1 Naturel
2 Accident Attending 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 看 6 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number rale 30. Name and address of person who completed ceuse of death (frem 23e) (Type, Print) JUAN HAPKIN 600 N. Wolf St Baltimon, MO 21257 Drake Charles G. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 8 Registrar

DHMH 16 Rev 6/95



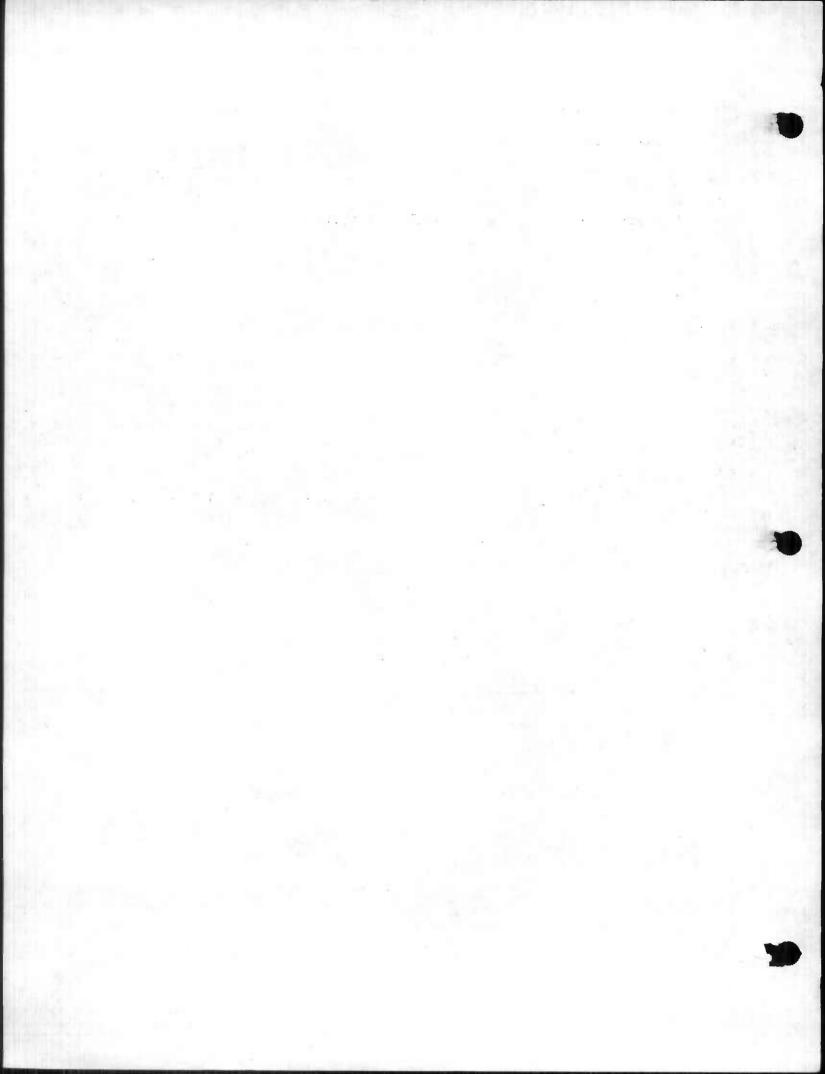
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 1450 William Gerald Dupree /Medical 4b. City. Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months Hours M 2□F Yrs. Director 1925 North Carolina 244-24-3427 JULY 29. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or learns 23e or 25e-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2049 Wilkens Avenue 21223 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Yeer or Detes: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1♥ Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) UNK. Crane Operator Steel Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be should be Mental h and Mental 7 is marked o William T. Dupree Lydia M. Evans 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n Mary L. Mowl/Niece 3079 High Street Manchester, MD Baltimore, 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removal from Stete 11-24-00 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. Baltimore, MD Delivin F. N.C.D. 22. Name and Address of Facility Cremation Society of MD, Inc. McDonald Mald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of). Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last and and Due to (or es a/consequence of) the attending physician ned for use as the burial Physician/Medical Que to (or es e consequence of): Acteremia Milliam Ingrec Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yaa 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed Deen certificate has 1 Yes 20 No 2 No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 100 27. Manmer of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of fnjury 28d. Describe how injury occurred 28c. Injury et Work? Certification: After Division 1 Divaturel 5 Pending investigation 1 Yes 2 No after death Director: 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 D Homicide To the Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hubbaro 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Counth Dav Davis 8:21 m tranceska 2000 4c. County of Deeth 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 700 W. 40 th St. Baltimore Baltimore City Keswick Multi-Care. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthpieca (State or Foreign Country) Months 1□ M 2₽ F Deys 89 219-42-6270 Oct. 14,1911 North Dakota Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits N/A Baltimore Maryland 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4000 N. Charles Street # 905 21218 USA 12. Wes Decedent Evar in U,S. Armed Forces? 11. Maritei Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14 Race - American Indien Black, Whita, etc. 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes: 1X Never Marriad 2 ☐ Married 1 ☐ Yes 2√2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) U.S. Government Managerial Supervisor 4 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumama) Unknown Maude Unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4000 N. Charles St. #904 Baltimore, Maroland Roy F. Matthews Friend 20b. Placa of Disposition (Name of cametery, crematory or other piace) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2XX remetion 3 ☐ Ramoval from State 11/22 5 ☐ Other (Specify) Balto. Washington Crematory Laurel Maryland 21. Signature of Funerei Service Licens 22. Nama and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 or the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart feilure. List only one cause on each line. Onset end Death immediete Ceuse (Finel diseese or condition resulting in death) Congestire Heart Failure 2 yrs 8 425 Ischemic Cardiongopalh Due to (or es e consequenca of): ATHEROSCIETOSIS OF CORDINARY Dua to (or es e consequenca of):

**Physician** /Medical Examiner

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To the Rospital of willing 24 hours e To the Funeral D

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Certification:

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P.O. Box 68760.

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Division of Vital

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**Physician** 

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Director

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic evant, tra Medical Examiner must be not tred at

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72 hours efter

filed within 7 Hygiene.

permit. Pages 1 and 2 should be filed to Department of Health and Mentel Hygie Important: If Item 27 is marked other 1 any Injury or other traumetic event.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in deeth) Lest Physician/Medical à Completed

Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. WITH COMPLETE HEART BLOCK (1999) THEARETING PERMANENT PACEMAKEL

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Was an autopsy performed?

2 X No 1 ☐ Yes 2 No 1 Yes

NOVEMBER 21, 2000

25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner steted.

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29a. Certifier (Check only one) 29b. Signeture and title of confl 29c. License number 29d. Date signed (Month, Day, Yaar)

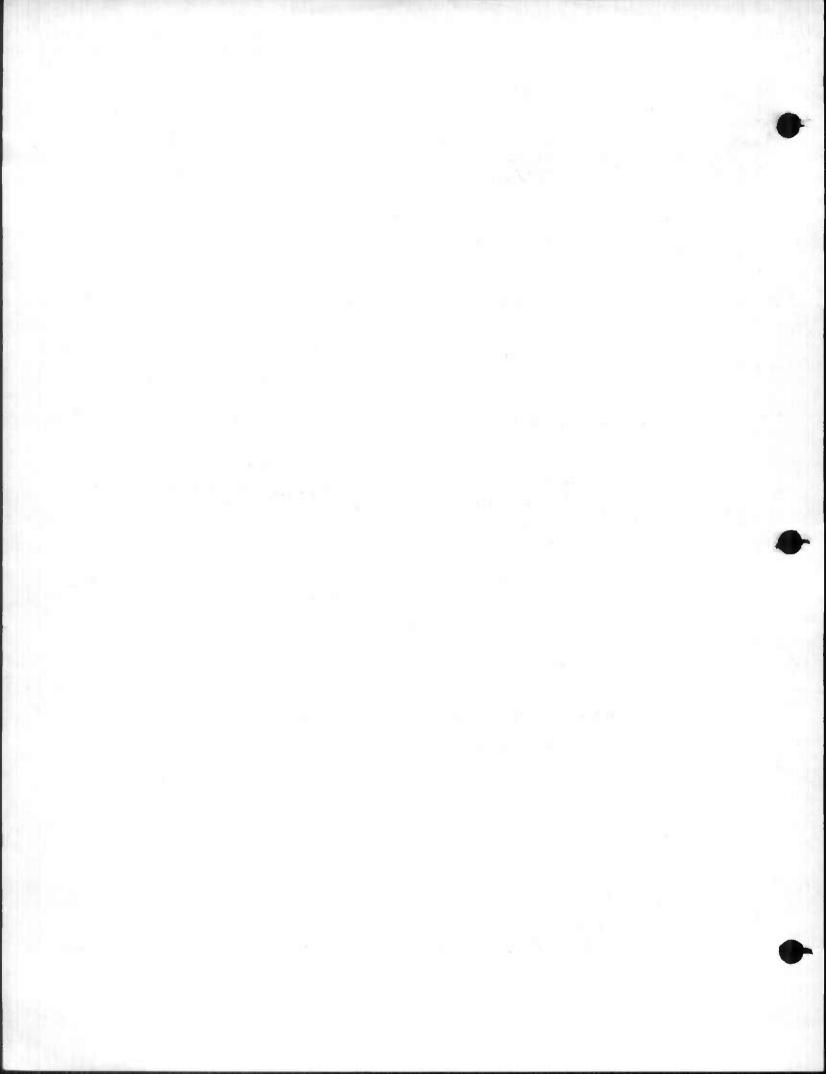
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

700 W. 40 Ms. BALTIMORE, m) CHARLES O JONOVAJ I, m) KESLICK 31. Dete filed (North, Par. Year) 2000

State Registrar

32. Registrer's Signature

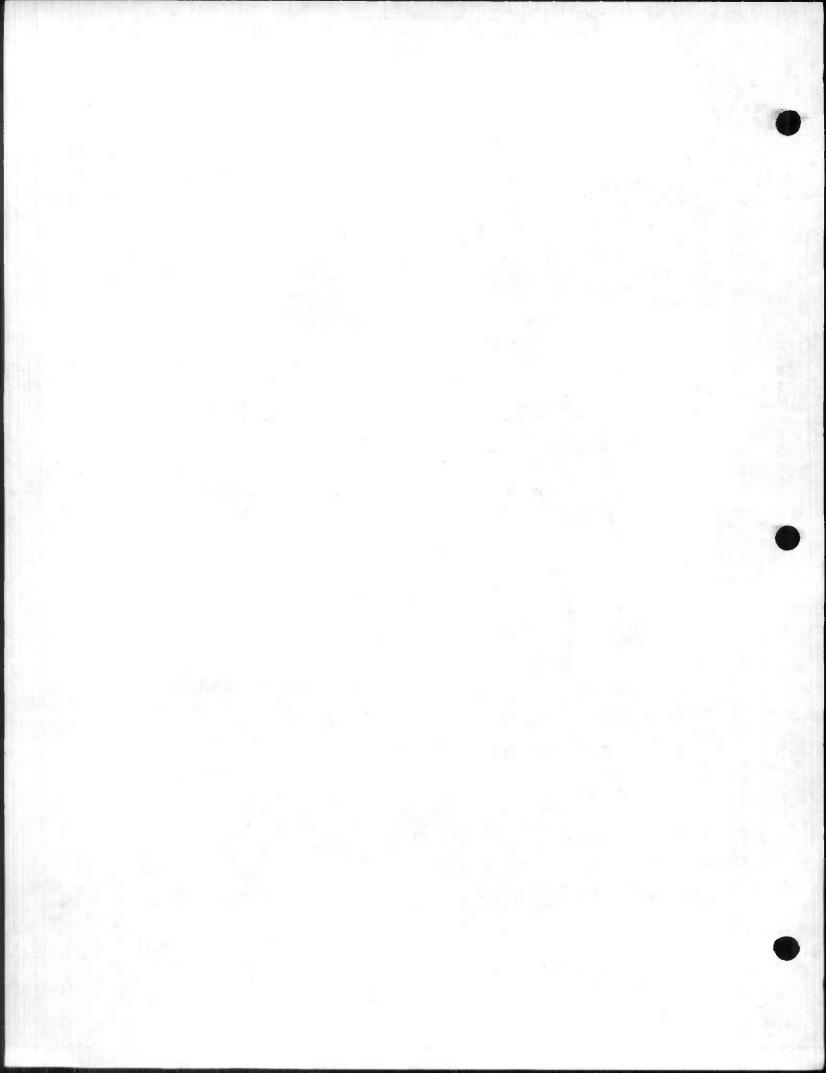
**DHMH 16 Rev 6/95** 



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State of Maryland / Department of Health and Mental Hygiene 00 37496

			Certificate o	f Death		Reg. No.					
Physician /Medical	Decedent's Name (First, Middle, Last     VIOLA	DELLY			2. Date of De Month No V	26 3	Year 2000 5:15 pm				
Examiner	4a Facility Name (If not institution, giva 900 CATON AVE		VES HOSPITAL	4b. City, Town, or BALTIM		,	TIMORE CITY				
Funeral Director	213-09-1727	7. Age (In yrs. last	t birthday) If Undar 1 Ya.  Months Day			y, Year)	Birthplaca (State or Foreig Country)     SC				
28a-f ahow notified at	Usual Residence of Decedent  10a. Stata  10b. County  MD • N/A		own or Location				10d. Inside City Limi N☐ Yes 2☐ N				
0 0	10e. Street and Number 27 04 W. BALTIMO	RE ST.	10f. Zip Code 2 1 2 2			10g. Citizen of What Country? USA					
ural, or hams 234 Earthur must	11. Marital Status  1 Never Married 2 Married  3 M Widowed 4 Divorcad	12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Co		Specify Yes or No to Rican, etc.)	Black	- Americen Indian, c, White, etc.				
iet ou se	15. Decedent's Education of the Company of the Company (Company (C	e completed)	16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	cupation ne during most of wo red)	rking	16b. Kind of Business/Industry					
ETTE m	Elementary/Secondary (0-12)  -12-  17. Father's Name (First, Middle, Last)	College (1-4or 5+) -0-	CAKE DECOR	me (First, Middle,	GROC						
Menta Menta arked atice	DAVID GLADNEY		dala Adalia Addisor (Cas		Y FEASTI		State Zin Code				
0 = ~ =	19a. Informant's Name/Relationship (7) BARBARA WASHING	BALTIMO	YLAND 21207								
it. Pages 1 and infiment of Haeli chart: If Item 2: Injury or other	20a. Method of Disposition  1 \( \emptyredge \) Burial 2 \( \emptyredge \) Cremation 3 \( \emptyredge \) Removal from State  4 \( \emptyredge \) Dongflion 5 \( \emptyredge \) Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other pleca)  MT. CALVARY CEMETERY  11-30-2000 GLEN BURN										
Departmen Important: any injury once.	21. Signature of Funeral Service Ligare	Bailey					ERAL SERVICE ARYLAND 21217				
hysician /Medical	23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the death. the cause on each line.		lying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death				
Examiner	resulting in death)  Due to (or as a consequence of):										
le dean certricale be associated the attending physician and hed for use as the burial-transit sciolary. Asician Medical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	s a consequence of):	The state of the s							
ed by the attendir detached for use	Part II. Other significant conditions con	-	stributa to the cause of dea								
cate has been signed by the attent page 2 should be detached for us Completed by Physician	DEGENERATIVE FOINT DISEASE  DEGENERATIVE FOINT DISEASE  1 Yes 2 PNO 3 P										
certificate has be rector, page 2 s					10	Yes 2 1 No	completion of cause of death?				
certificate rector, pag	25. Was case referred to medical axaminer?				ath (Check only	one)					
After this funeral di	1 Yes 2 No  27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	1	3b. Time of linjury 28c. Ir	Other: 4 Nursing I jury at Vork? No		dence 6 Other					
within 24 hours effer death. To the Funeral Director: Affer to completely filled in by the funeral Medical Certification:	3 Suicida 6 Could not be 4 Homlcide determined	28e. Placa of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location ( City or To		er or Rurel Routa Number,					
n 24 hour ne Funer pletely fill edical											
withir To the	29b. Signatura and titla of certifiar	196 Regident.		D-44897			(Month, Dey, Year)				
	30. Name and address of person who or ST. AS NES HOSPITAL.	ompleted cause of death (Item 23	Ba) (Type, Print) ICHE				redicine,				
State	31. Date filed (Month, Day Year)	32 Registrar's Sighatur		, 1000	- 1 - 2 - 7	W.					



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death November 20, 2000 Physician Evelyn Virginia Ehrensberger 1:50 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Future Care Chesapeake Anne Arunde1 Arnold | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth | 9. Birthplace (State or Foreign Country) | September 5,1913 | Minnesota 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□M 2₩F 87 Yrs. 388-09-1466 Director Usual Rasidence of Decedent 10a Stata 10b. Counts 10c. City, Town or Location 10d. inside City Limits Annapolis Maryland Anne Arundel 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Hygiera. other than "natural", or items 23s or vent, the Medical Examiner must be. 764 Windgate Drive 21401 U.S.A. Funeral 12. Was Decedant Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married Saltimore, Maryland 21215-0020 White 1 ☐ Yes X No Specify: à 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed vitnem of Health and Mental Hygin Tant: If hem 27 is marked other 1 dury or other traumatic event, Ib 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Adolph Gertrude Lindseth Olson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 764 Windgate Drive Annapolis, Maryland 21401
Disposition (Name of Date 20c. Location - City or Town, Stata Mrs. Kay L. Himmelmann (Daughter) 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1 Buriel 2X Cremation 3 Removal from Stata Chesapeake Cremation Ctr. 11-22-00 Stevensville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave. S.W. Glen Burnie, Maryland 21061 or complications that ceusad the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition ESPIRATORY Examiner resulting in death) Due to (or es e consequence oi):
-Xacerbation of Emphyseum

Due to (or as a consequence oi):

rouce destructure Pulmonery Direction or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? evelopovarular Accident 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? 2 0 NO 1 Yes 1 ☐ Yes 2 ☐ No 89 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this

1 Yes 2 No 27. Manner of Death 5 Pending

1 Natural 2 Accident investigation 6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, straet, fectory, office building, etc. (Specify)

29c. Licansa number

28c. Injury at Work?

12 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date and place, end due to the cause(s) and manner es slated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

LAWY, PASADRNA MD 21122

29a. Certifier

(Check only one)

1 Yes 2 No

29d. Date signad (Month, Dey, Year)

30. Nama end address of person who completed cause of death (Item 23a) (Type, Print)

8021 RITCHIE CYRIAC MD

ywee MD

31. Date filed (Month, Dey, Year) NOV 2 8 2000

32. Régistrar's Signature

Altending Doctor

28b. Time of

**DHMH 16 Rev 6/95** 

after death.

Director: After tit
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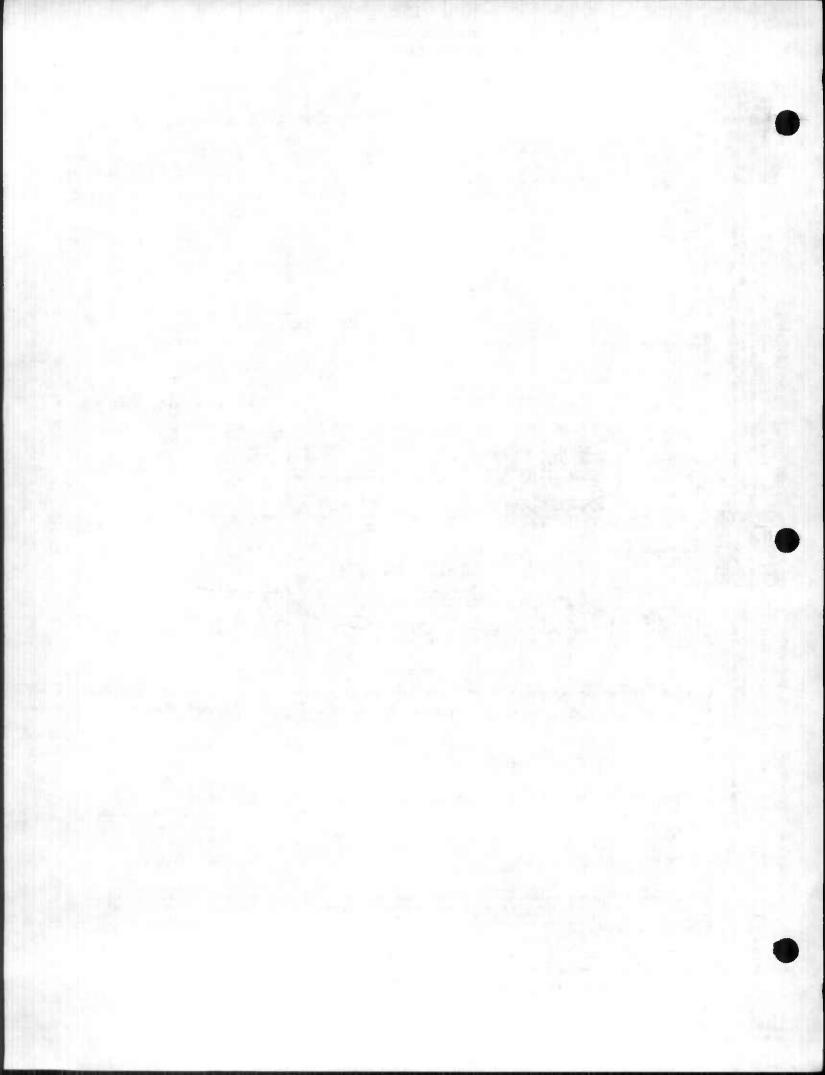
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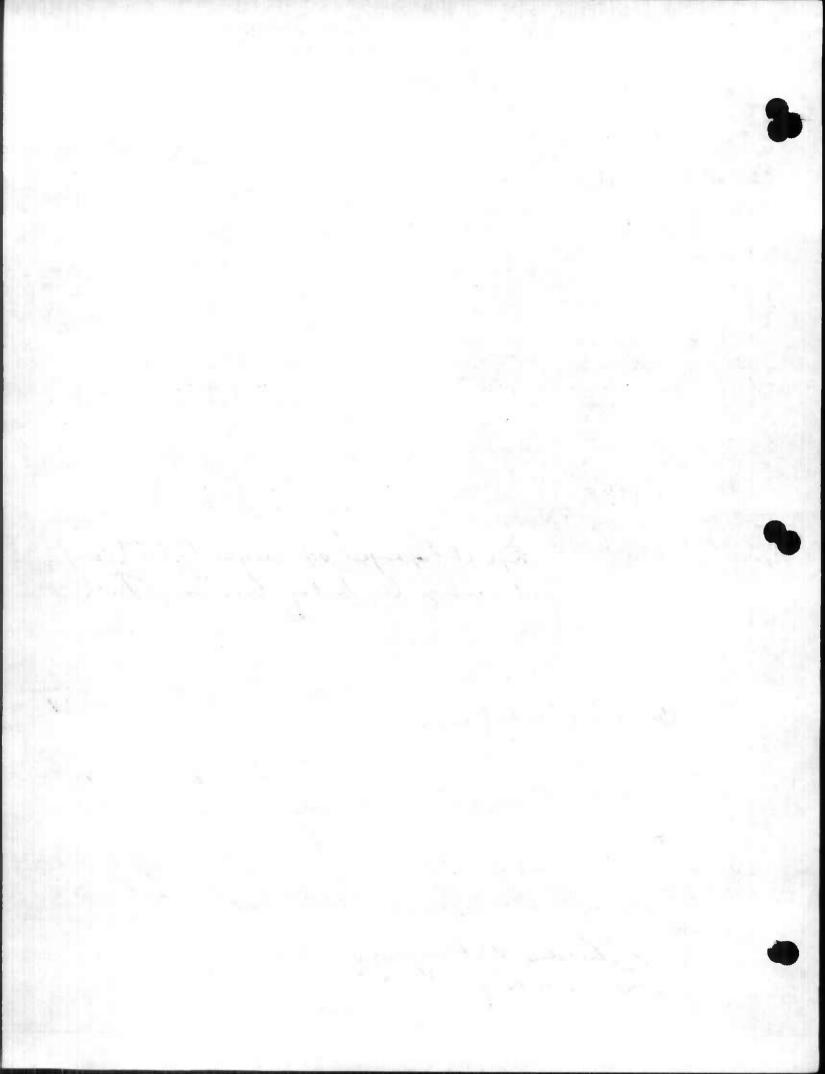
State of Maryland /

Department of Health and	Mental Hyg	iene	n	3	1
Certificate of Death		. 0	U	V	l

WILLIAM E	VAN	NS	State of I	Marylan		artment o			nd M		giene	3	749	8
		Decedent's Name (First, Middle, Last)									ath	Vees	3. Time	of Death
Physici /Medi		William Lawson	Evans. J	r.						Month NOV.	25, 20	Year 00	15	45 PM
Examir	_	4a Facility Name (If not institution, give					4b	City, Tow	m, or Lo	r Location of Death 4c. County of Deeth				
		ST.AGNES HOSPIT	AL				- 1	BALT1			n/a			
Funeral		5. Social Security Number 6. S	ex 7. DXM 2□ F	Age (In yrs.	last birthday) Yrs.	Months De	eer eys	If Under 2 Hours	Min.	8. Dete of Bir (Month, Da				e or Foreign
Director		212-52-9692 Usuel Residence of Decedent		53	115.					Jan 10	, 1947	Mar	yland	1
pue a		10a. State 10b. County		10c. City	y. Town or Lo	cation			100			1	Od. Inside	City Limits
Mary La	to	Maryland Baltimor	<b>P</b>	н	aletho	rne							1 🗆 Y	es 2/2 No
1 the	Directo	10a. Street and Number			arcene	10f. Zip Co	de				10g. Citizen of N	What Coun	itry?	
death with the Maryland ms 23a or 28a-f show mast be notified at	a D	1714 Summit Aven	ue			21	227				U.S	. A .		
	Funeral	11. Marital Stetus	12. Wes Decede Armed Force		S. 13.			panic Orig	in? (Spe	pecify Yes or No- to Rican, etc.) 14. Race - American I Bleck, White, etc.				
9 e e e		1 ☑ Never Merried 2 ☐ Married	1 Yes 21			1□ Yes 2[v]		Specify:		Specify: Whit				
5-0036 72 hours after natural; or the	d by	3 Widowed 4 Divorced	Yeer or Dete	is:	40. D.			V	16b. Kind of Business/In					
15-	ete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usuel O kind of work d DO NOT use re	one du	ion uring most	of worki	ng	160. King of 6	usiness/inc	Justry	
within then.	E O	Elementery/Secondary (0-12)	College (1-4	or 5+)		ok	,				Hos	pital	its	
D High	Be Completed	17. Father's Name (First, Middle, Last)	Market Market		18. Mother's Neme					(First, Middle			LLY	
Maryia od 2 should ith and Men 27 is marke r traumatic	0 8	William Lawson Ev	ans, Sr.				2	Isa	bel:	la Hedr	ick			
		19a. Informent's Neme/Relationship (7			19b. Meilli	ng Address (St	treet ar	nd Number	r or Rura	il Route Numb	er, City or Town,	State, Zip	Code)	
		Donna E. Wright /	sister			Harnes	_		nto	nio, TX				
altimore, mit. Pages 1 ar partment of Hea portant: if item 3 y injury or other		20e. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removel from Ste			sition (Name on matory or other		)		Date	20c. Location			
Page ment of the transfer of t		4 □ Donation 5 □ Other (Specify		Bay	view (	Cremato	ry		11	/29/00	Baltimo	re, l	Maryl	and
Ball Separation of the poor		21. Signeture of Funerel Service Licen	see Qi	V.		2. Name end A				T.				
W.		23a. Pert1. Enter the disease, or com shock, or heert feilure. List only	· Xu		4	lubbard	1ke	ns Av	enue	a. Balt	imore.	Marvl	and	21229
Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	Ruptu	10	r as e conse	geel	Va	hei		inth g	Jestion	test	Onset an	7
cords, P.O. Box 68760, requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	n/Medicai Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c		r es e consec			7			790		1	
death death of for	Sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.								23b. Did	tobacco usa co	ntributa te	o the caus	se of death?
ords, P.O. requires that the seen signed by the hould be detached.	y Phy	Chrome al	whole	- and	e					10	Yaa 2□No	3 Pro	bably 4	Unknow
0 \$ 20	Completed by Physician/Med				-				_		an eutopsy ormed?	ev av	ere autop: ailable pri impletion death?	sy findings or to of cause
The law	E O									1/0	Yes 2□ No	1[	Mes 2	2□ No
Vital itelan: T certificat rector, p	Be	25. Was case referred to medical examiner?					1		of Death	(Check only	one)			
VISION Of VITA Attanding Physician: or death. ector: After this certific by the funeral director,	2	1⊠ Yes 2□ No	Hospitai: 1 ☐ Inp	atient 2 🖾	ER/Outpatie		Other	4 🗆 1901			dence 6 Dot		y)	
ng Pl		27. Manner of Death  S☐Netural 5 ☐ Pending	28a. Dete of I (Month,	njury Day Year)	28b. Time o Injury		Injury Work			28d. Describe	how injury occur	rred		
DIVISION Of t or Attending Physiatier death. Director: After this t in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 N						
DIVI after da Direct	틭	4 Homicide determined	266. Place of	Injury - At ho etc. (Specify	ome, farm, str	reet, fectory, of	ffice				Street and Num. wn, State)	ber or Run	al Route N	lum <i>ber</i> ,
Diffee of the control		One Continue all contains			1-4-4-0			4.4	1 1					
Hose 24 ho Fund staly f	edical	29e. Certifier (Check only one)  1 Certifying Phyone  2 Medical Exam	iner: On the basis	s of examine										e(s)
DIVISION Of VITAL HC To the Hospital or Atlanding Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Mec	29b. Signeture and title of certifier 29c. License number									29d. Date algne	ed (Month,	Day, Yes	r)
F 3 F 8		0.C.M.E								NOV.		200		
		30. Name and address of person who of	completed cause	of death (Hor	200) (Turn	Print)								
3			Completed cause of	I death (item	11 Per	in Stre	et,	Balt	imo	re, Mar	yland 2	1201		
Sta	ite	31. Dete filed (Month, Day, Year)		istrer's Signe	ture	-	6	-37						
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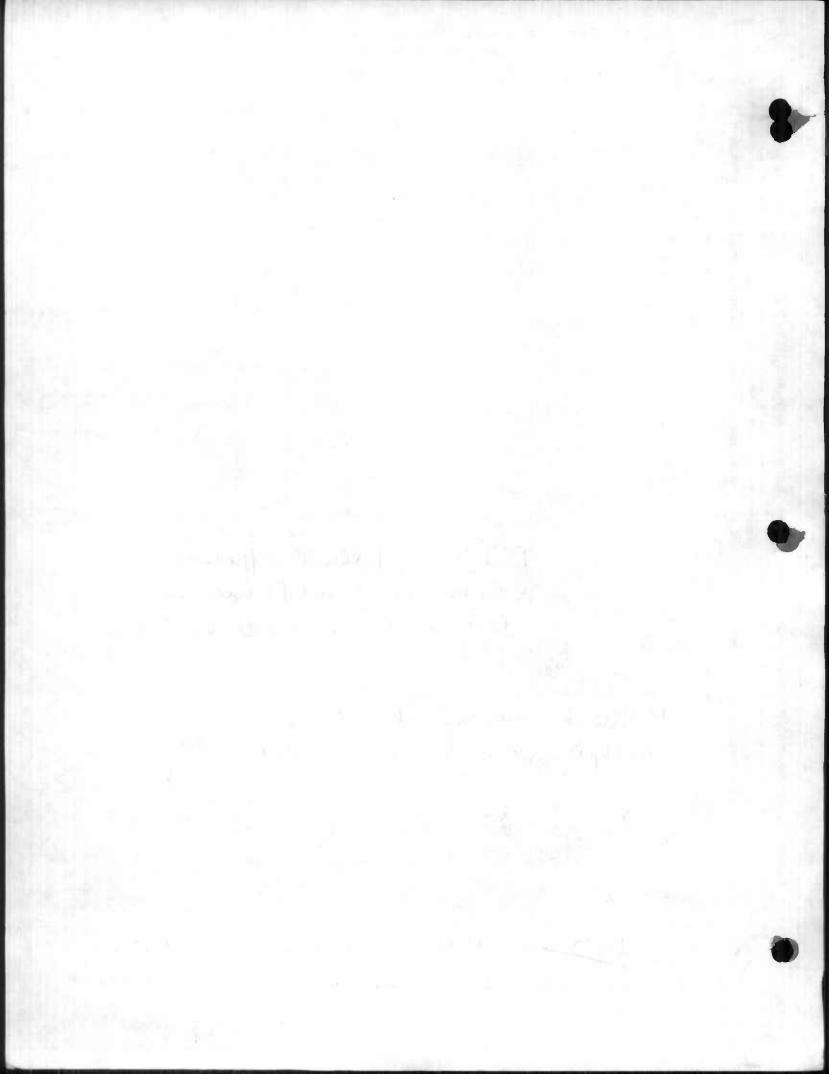
DHMH 16 Ray 6/95

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Physician		's Neme (First, A	Aiddle, Last)						2. Date of De Month	ath Dey	Yeer	3. Time of Death
Physician /Medica	Hote	ie Eliza	beth	Evans					NOVEN		2002	4.551
Examine	4a Conitity t	Name (If not instit			mber)	1 13		4b. City, Town, or L	ocation of Death	4c. County	of Death	
		i Hospit	- 1					Baltimor		7	A\T/A	
Funeral		curity Number	6. Sex	(	7. Aga (In yrs	. lest birthday)	If Under 1 Year	If Undar 24 Hrs.	8. Defe of Bir	h .	9. Birthple	aca (State or Foreign
Director	213-	14-2374	10	M 2XF	97	Yrs.	Months Deys	Hours Min.	(Month, De SEP 24.		Count	w Carolina
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wor.	10a. Sfeta	10b. Co	unty		10c. C	ity, Town or Lo	cafion				10	d. Inside City Limits
the Meryler 28a-f show	Maryl	and N/A				Baltim	ore				-	1 Yes 2 □ No
Post in the second seco	10e. Sfreef					Dartin	10f. Zip Code			10g. Citizen of W	Vhet Count	ry?
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Herma Herma	1 Nov	er Merried 2		Armed Fo	rcas?	if	Yes, specify Cub	en, Mexican, Puerto	Rican, etc.)		k, White, e	
20 is at		owed 4 Divo		1 ☐ Yes If Yes, Gir Yaar or D	ve 2 2	1	☐ Yes 2 No	Specify:		Specify	1	
nd 21215-0020 e filed within 72 hours after al hygiene. other than "natural", or its vent, to Wedle Every	Z Z		edent's Edu		4143.	160 Deced	ent's Usuel Occup	nation		16b. Kind of Bu		ack
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should by and Menta marked amarked		n W. Jus						Francis			UNK	
0.000		ant's Neme/Rele						t end Number or Ru	ral Route Numb	er, City or Town,	Stete, Zip	Code)
other tr			homps	on/Gra				sea Road	Baltin	ore, MD	212	16
OTG of H		of Disposition	ion a CID	lamaral fram		Plece of Dispos cametery, cren	sition (Neme of netory or other ple	ce)	Dete	20c. Location -	City or Tov	wn, State
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Baltimore, peemit. Peges 1 s Department of He Important: If Nemany Injury or othe once.	21. Signatu	re of Funarei Sac	vice Ligense	90		22	Nama and Addre	ass of Facility			- CAMO	
Ba Depa		Thomas	) Dy	u				Society				
		nomas Gr		ications that o	raused the des			rick Road		imore, N	1D 2	1228 Approximete
	shock	or heart failure.	List only or	ne cause on e	ech line.							Interval Between Onset and Death
⊅hysician /Medical	Immediate	Ceuse (Finel		0	0-1		00.		0.			
Examiner	disease or resulting in	condition		131	lal	escal	the	nal l	Music	n		
					Due to	(or as e conseq	uence of):	0	10			
axecuted and faltransit		congestere heart failing										
and -trar	Sequentially	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury)  Cause (Disease or Injury)  Cause (Disease or Injury)										
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dS, P.O. BOX ( ires that the death certif signed by the attending d be detached for use a				1							1	
dead dead dead dead fo	Part II. Othe	r significant con	ditions con	tributing to d	eath but not re	sulting in the ur	nderlying cause git	ven in Pert I.	23b. Did	tobacco uss cor	ntribute to	the cause of death?
O. of the mache	0	1 1-	0	0	1	0 1	-		10	Yss 2□ No	3 Prob	ably Unknown
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Records, he law requires the has been signe age 2 should be completed by		. 1	0	_	A A					an eutopsy	24b. Wa	ra autopsy findings
The law requirements the law seen signals and page 2 should completed.	//	Mello	le	Clese	la 1	1an Cul	a ac	Cident	perto	ormed?	cor	illeble prior to npletion of cause deeth?
Rec law has by ye 2 s		1								A .		
									10	Yes 2 No	1 🗆	Yes 2 No
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original ori	2 🗖 Acc	ident in	vestigetion				M 1	Yes 2□No				
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in particular	3			Dania	ing, etc. (opec	ary)			Ony or 10	, Otolo)		
ospital ty fined		r 1X Cert	tifying Phys	ician: To the	best of my kn	owledge, deeth	occurred et the ti	me, date end place,	, end due to the	cause(s) and ma	nner as st	ated.
Division To the Hospital or Attending The Fundam after death. The Fundam Director: After The Fundam of the fundam	(Gheck one)	only 2 Med	ical Examir	ner: On the b	asis of axamin ner steted.	etion end/or inv	estigation, In my o	opinion, deeth occur	rred et the time,	date end pleca,	end due to	the ceuse(s)
		ure and little of ca	rtifier				29c. Licens	se number		29d. Date signed	d (Month, I	Day, Year)
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State Registrar		d (Month, Dey, Y	8 201	32. H	legistrar's Sign		1	1				

DHMH 16 Rsv 6/95



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B.K.S		State of Maryla	nd / Depa	artment of	Health and	Mental Hyg	giene () (	1 37	500			
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	Decedenf's Name (First, Middle, Last	)				2. Deta of Dea Month		Year 3. 7	Time of Death			
Physician Medical	111111111111111111111111111111111111111	ELLERBE				NOV.	22, 200	0 (	0645 AM			
Examiner	40 Capitle Bloms III and leading the sheet	street and number) 5- 401 EAST M	ADISON	STREET	4b. City, Town, or BALTIM	Location of Death	4c. County o	f Death				
Funeral	5. Sociel Security Number 6. Se		last birthday)	If Undar 1 Yaa Months Deys			h (, Year)	9. Birthpleca ( Country)	State or Foreign			
Director	212-86-9795 Usual Residence of Decedent	XM 2□F 34	Yrs.			JULY 5		MARYLA				
thow Lat	10a. Stata 10b. County	10c. C	ity, Town or Lo				V-101-0		side City Limits			
off the Ma	MARYLAND N/A		BA	LTIMORE					Yes 2□No			
		E AVENUE		10f. Zip Code 21	239		U.S.	A .				
fine death of their said	11, Marifal Status	12. Wes Decedent Evar in the Armed Forces?	U,S. 13.	Was Decedent of	Hispenic Origin? ( ban, Mexican, Pua	Specify Yas or No- rto Rican, etc.)		- American inc				
21215-0020 dwithin 72 hours after period or the their health of the their health of the Medical Examina Completed by Fu		1 Yes 2 No If Yes, Give Yaar or Dates:		1 □ Yes 2 No		,	AFRO Specify:	-AMER	ICAN			
S-0 72 ho watum watum	15. Decedent's Edu (Specify only highast grad	acetion	16a. Deced	dent's Usual Occu	upation e duning most of wo	ndring						
I 21215-0 led within 72 ho lygiene. we then "neturn it, the Medical is Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				Jinny						
C Harried	11TH		LA	NDSCAP1		ama (First, Middle,			scaping			
and the state of t	17. Father's Name (First, Middle, Last)  JACKSON ELLE	RBE			AN WATK		,					
Maryland d2 should be the d2 should be the t7 is marked othe traumatic event	19e. Informant's Name/Relationship (T		19b. Meilie	na Address (Stree	et and Number or F			State, Zip Code	))			
M Manual S	FRANCINA CLAY							D. 21218				
Ore of He filtern r offbr	20a. Method of Disposition  1x Burial 2 □ Crametion 3 □ F		Place of Dispo cemetery, cref	sition (Name of matory or other pl		Dete	20c. Location - (					
Baltimore semir. Pages 1- Separtment of He mportent; if then my injury or oth stick.	4 □ Donation 5 □ Other (Specify)	M'		CEMETE		7.29,200	0 BALT	O, MD.	•			
Ball Separation and an anger	21. Signatura of Funarel Service Licens	2		Name and Add	ress of Facility  B. SCRUC	GS FUNI	ERAL HO	ME	21212			
40440	Dernadine!	1. Acrus	6/ 1	412 E.	PRESTON	STREE	r BALTI	MORE,	MD:21213			
	23a. Part1. Enter the diseese, or comp shock, or heart feilure. List only of	ne cause on each line.	Mn. Do not ant	er tha moda of dy	ring, such as cerdia	ac or respiratory ar	rest,	Inter	roximete val Between et and Death			
/Physician /Medical	Immediate Cause (Final	DE ONO IO PARTIE DE										
Examiner	disaasa or condition resulting in deeth)	BRONCHOPNEUM	ON LA (or as e consec	nuence of):				1				
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760, te be expression en expre	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury											
filicate g phys as the edic	that initiated events resulting in death) Last Dua to (or as e consequence of):											
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O. B. in death the attend for valcie	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying ceuse g	given in Part I.	23b. Did 1	obacco usa con	tributs to the	causs of death?			
that the distance by the detached	NARCOTISM					10	Y88 2,⊠ No	3 Probably	4 Unknown			
d be d			-211-			240 18/00		24h Were su	utopsy findings			
al Records, P The lew requires that take has been signed to page 2 should be det.  Completed by P				4-1-			an autopsy med?	evailable	e prior to ion of cause			
The lew rate has be page 2 s						457	( ADN-	of deeth				
Vital I	25. Was case referred to medical				20 Bloom of D	eeth (Check only o	res 2□No	1 JQ Yes	2 No			
Of Vita Physician: this certific ral director,	axaminar? 1 ∑ Yes 2 □ No	Hospitel: 1   Inpatient 2[	☐ ER/Outpatier	nt 3D DOA		Home 5 ☐ Resid		(Specify)	AT SCENE			
g Physical Court of the court o	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ury at	28d. Describe	now injury occurre	ed				
Attending Attending or death.  Ctor: After by the fune fiffcation	1 Netural 5 Pending 2 Accident Investigation				Yes 2□No							
D page i	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, ferm, str ify)	reet, fectory, offici	В	28f. Location (S City or Tox	Street end Numbe vn, State)	er or Rural Rou	te Number,			
Funeral Funeral Cedical C	29s. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kn ner: On the basis of examin and menner stated.							ceuse(s)			
Me Apple	29b. Signatura and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
T.	1 At An	1 1/1 -1	× M	0.0	C.M.E		NOV.	23, 20	000			
Last.	30. Neme and address of person who co	ompleted ceuse of death (Ite	m 23a) (Type,	Print)								
(A)	Stephen S. R	adentz, 1			, Baltimo	ore, Mary	land 212	201				
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1								

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